Rocky Mountain Medical Journal

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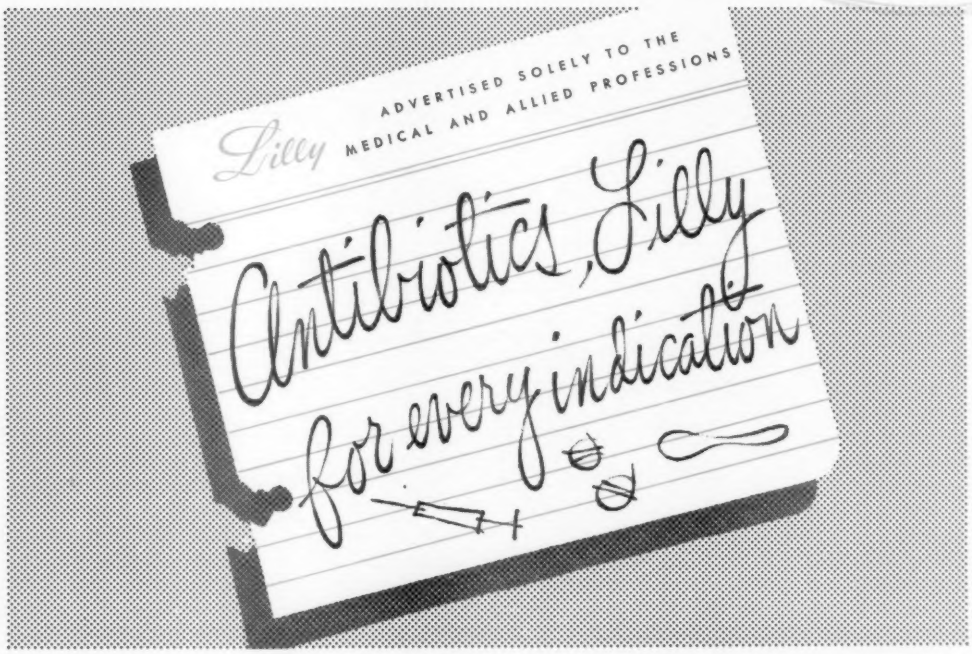

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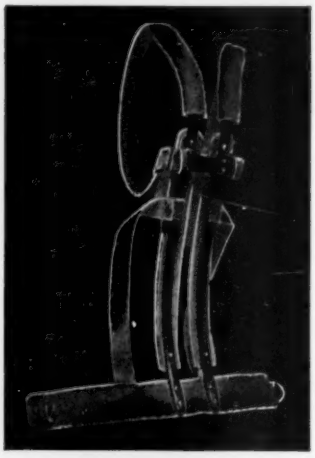

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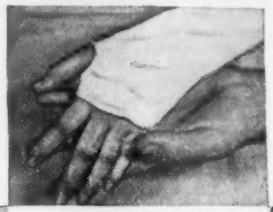

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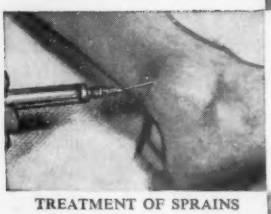

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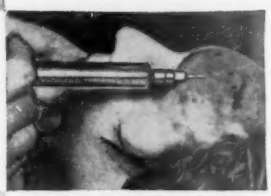

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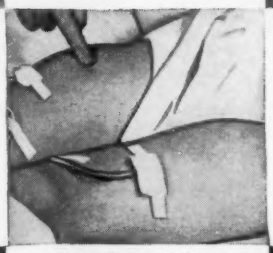

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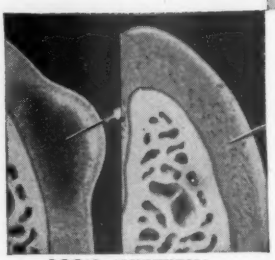

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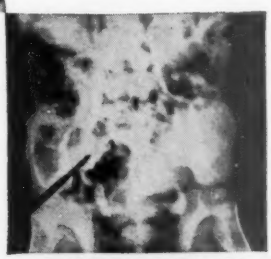

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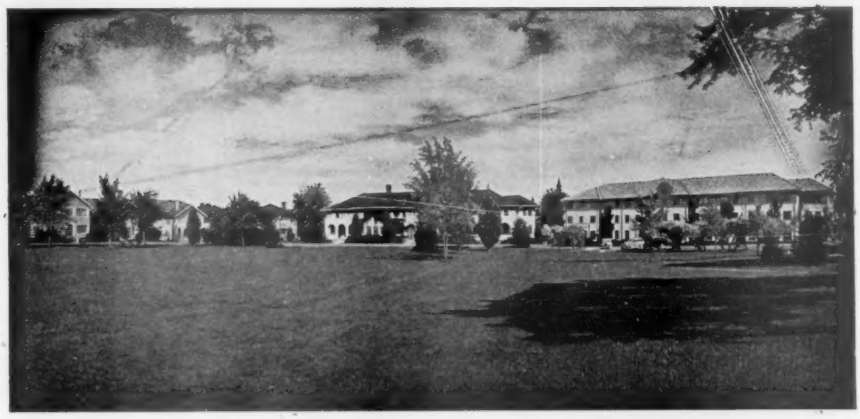

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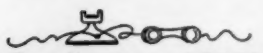

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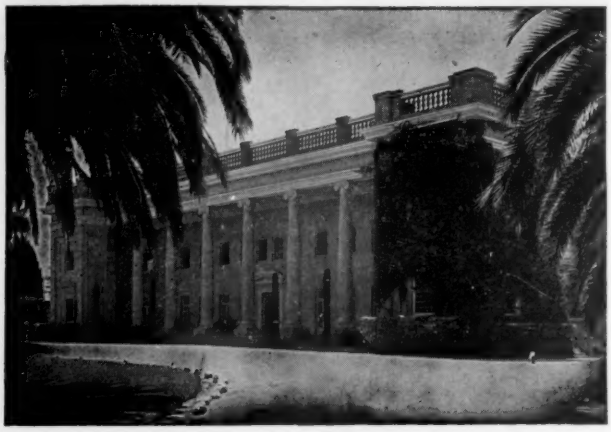

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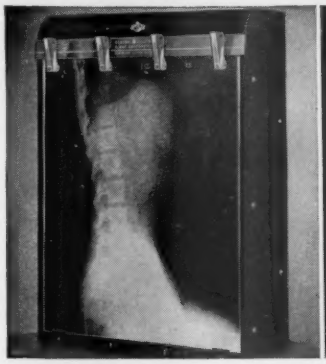

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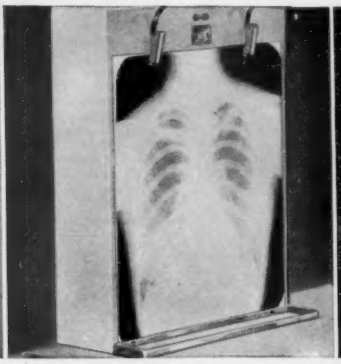

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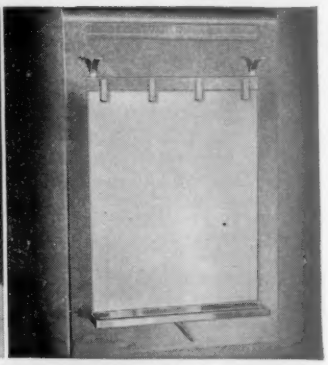

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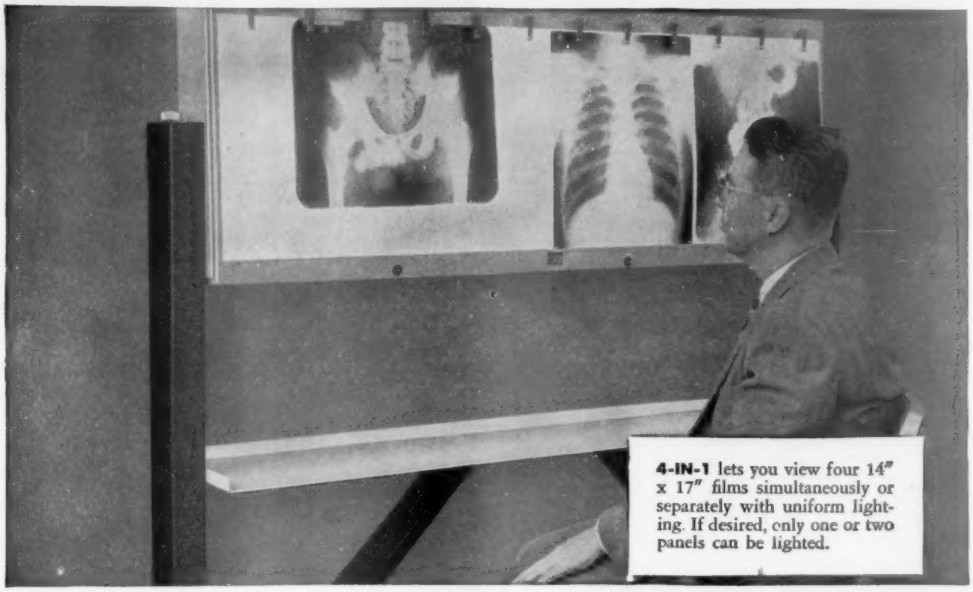

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Cancer Committee: Richard Call, Salt Lake City; Ralph R. Meyer, Salt Lake City; J. H. Carlquist, Chairman, Salt Lake City; Ralph C. Ellis, Ogden; Ray T. Woolsey, Salt Lake City.

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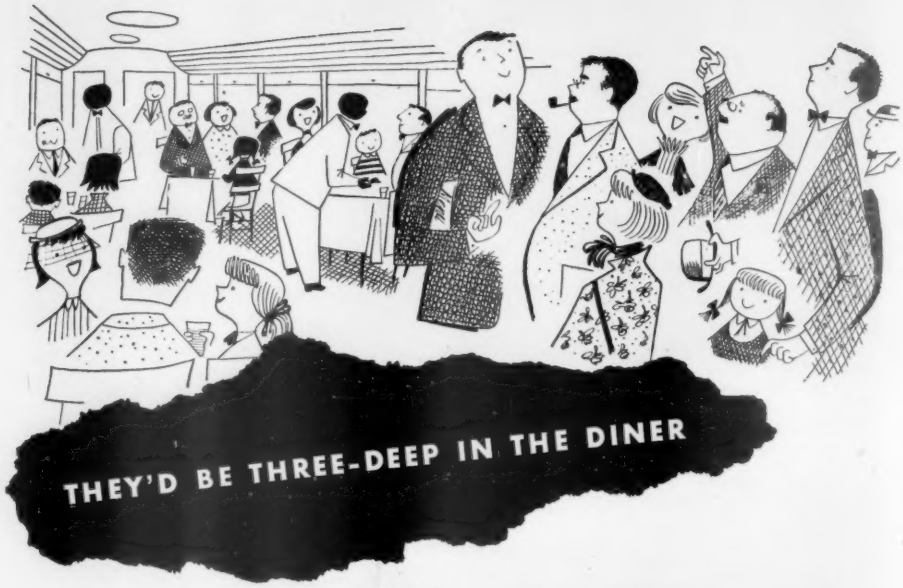

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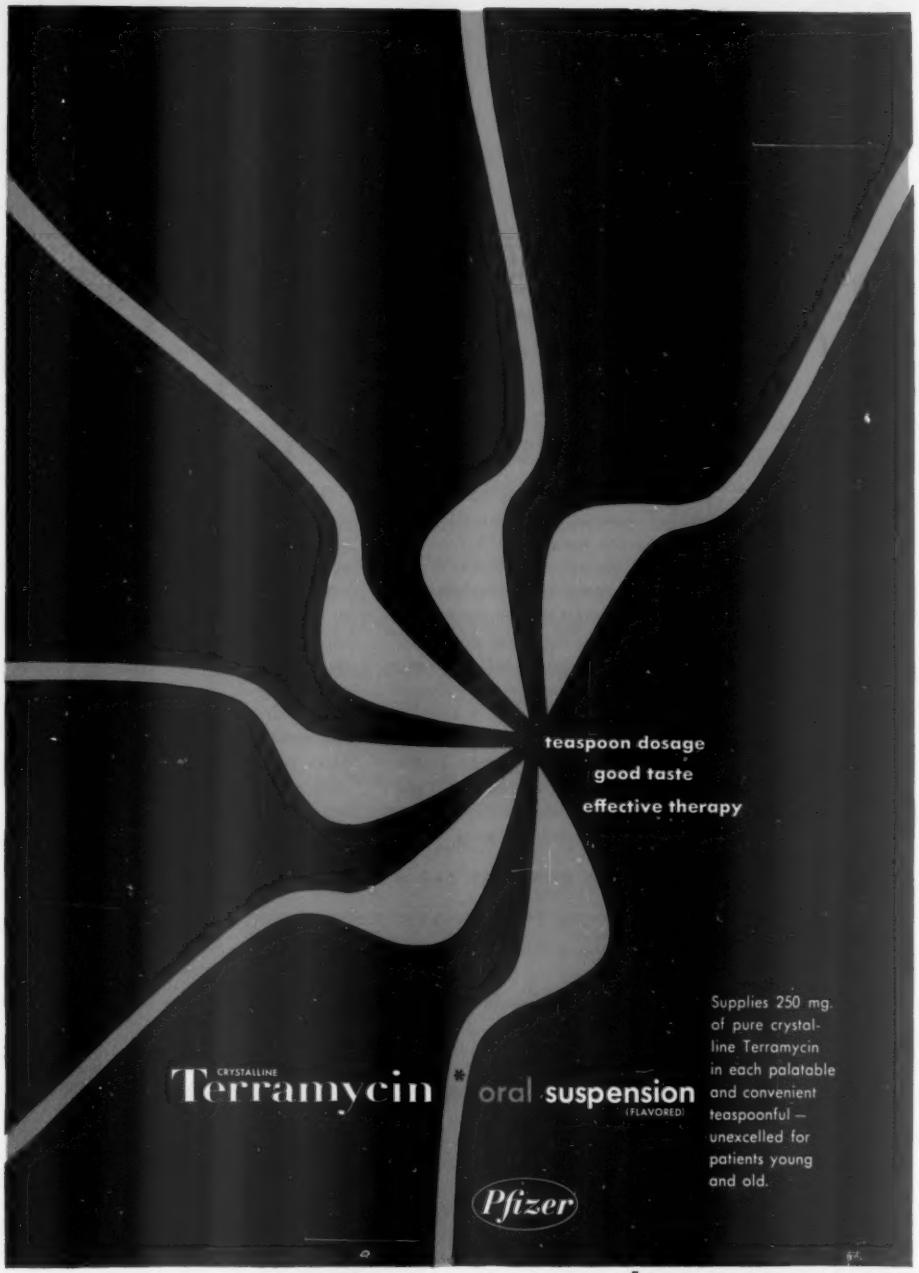

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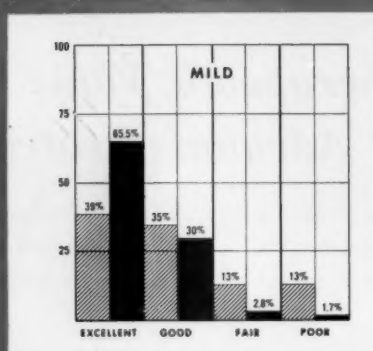

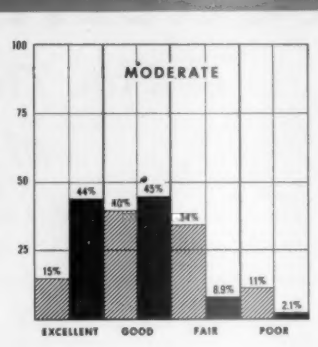

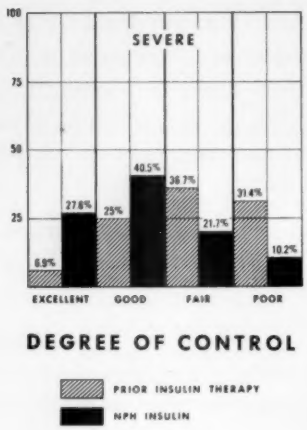

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Rocky Mountain Medical Journal

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FEBRUARY
1953

Editorial

Medicine's Major Objectives for 1953

THE PRESIDENT of the American Medical Association, Dr. Louis H. Bauer of Hempstead, New York, has outlined a nine-point program for the "preservation of our American system of medicine." The nine points are directed to all physicians and component societies:

1. Work with rural communities to establish facilities for physicians, so that we shall have a better distribution of physicians.
2. See that good medical care for the indigent is available everywhere, just as it is in some states.
3. Extend public health coverage to areas lacking it.
4. Develop plans for the care of the chronic invalid.
5. Expand our voluntary insurance program, not only to cover more persons, but to cover those over age 65 and those suffering from illness of long duration.
6. Clean our own house, by disciplining those physicians who are tarnishing the reputation of the whole profession by their unethical acts of over-charging, accepting kick-backs, and making commercial arrangements with pharmacists.
7. See that the public is protected so that they can always obtain the services of physicians.
8. Revitalize our County Societies and make them leaders in their communities in all health matters.

Dr. Bauer said that there also are "certain legislative matters that will require our attention and earnest study." He listed them as follows:

1. The establishment of a department or independent agency of health in the federal government. It must not be tied in with education or Social Security. Health is important enough to warrant an agency by itself.
2. The making of constructive suggestions for the solution of the problem of the totally disabled under the Social Security Law.
3. Obtaining sufficient physicians for the armed forces, without injustices or upsetting civilian medical care programs.
4. Enactment of a law allowing pensions or retirement privileges for the self-employed, along the lines of the Reed-Keogh bill introduced in the last Congress.

Dr. Bauer has also mentioned the solution of problems related to the Veterans' Administration. The main problem of concern to medicine has to do with the staggering percentage of non-service-connected disabilities being treated in V.A. hospitals. This is a gross injustice to the taxpayer. This constitutes direct government competition with the private practice of medicine and with private hospitals and other public hospitals. It tends to pauperize hundreds of thousands, probably millions, of citizens. It is a part of that socialism which every real thinking American opposes once he thoroughly realizes its implications. It should be, must be, halted in its tracks. Still another problem facing these V.A. hospitals (and they themselves are not causing the problems—Congress caused them with careless legislation) is the significant and apparently increasing amount of malingering by veterans.

It is our money that is being spent, our tax money. And it is we whose livelihood as private practitioners is being undermined at the same time. We cannot rest concerning these matters.

Medical Veterans Answer Admiral Pugh

EVERY physician who served in any of the Armed Forces in World War II should read, and think about, the following excerpts from the San Diego Medical Bulletin and a letter from Dr. Clifford L. Graves, its Associate Editor:

From the Bulletin:

It is now becoming obvious that the Armed Forces have not lost their voracious appetite for doctors. Dr. John B. Price of the Orange County Medical Veterans cited a typical example, the authenticity of which he vouches for. Not very long ago, the commanding medical officer at an Air Force base opened an obstetrical and pediatric ward, so that he could maintain his patient-census above 100. With a census above 100, his base would be entitled to a five-million-dollar hospital.

The Armed Forces shrug off the number of medical officers they need for the care of dependents as "a mere 250." Actually, the number runs into the thousands. Pentagon officials are so tight-lipped about it that an investigating committee gave up after trying to find out for two years. Those who are in a position to know place the figure at a minimum of 35 per cent. Medical care of dependents may be justifiable **under certain circumstances** but doctors should never be drafted for this purpose. There is a more American way.

I well remember my first experience as a young medical officer at Fitzsimons Hospital in 1941. Once a month, I had to take a week off from my duties on the drill field to take inventory in the Post Exchange. I asked my commanding officer if he thought he needed a **medical** officer to count boxes with pencils. "Of course," he said in utter astonishment. "We have **always** had medical officers for that."

To feed medical manpower to this hungry monster, Public Law 779 was hastily drawn up and passed shortly after Korea. By admission of one of its authors, it was the result of a "mad week-end" and it has been making doctors mad ever since. Certainly, World War II veterans had no voice in it.

Public Law 779 runs out on June 1. Groundwork for a new law has already been laid, and Admiral Pugh [Rear Admiral Lamont Pugh (M.C.), U.S.N., Surgeon General of the Navy] sounded the keynote. Doctors are just money grabbers, he says. The A.M.A. protested and its House of Delegates passed a resolution and that's that. Civilian watchdog committees are powerless. Meanwhile, Congress will start hearings within a few weeks and vote a new law into existence by the middle of February. Time is short. Very short.

These are the grim facts San Diego veterans learned last month from Dr. Roy Averill and his newly formed society. And San Diego is not alone. Similar organizations are springing up all over the country. Perhaps something can be done. But it will take concerted and swift action. This is not the time to pass another resolution. It is time for a nation-wide delegation of medical veterans to go to Washington and place the facts before the Congressional committee. Briefly, the platform is this:

(1) Misuse of medical officers should stop; (2) Physical requirements should be revised sharply downward; (3) Non-veterans should be called before veterans; (4) Interns should not be deferred to start residencies.

From Dr. Graves' letter:

The point is that the Armed Forces are recalling medical personnel without any attempt at correcting the mistakes of the late war. We, who saw the medical department at work, vividly remember the waste, the inefficiency, and the abuses. "Always send **ten** medical officers when you need **one.**"

The Medical Veterans' Society is the first organization to give a voice to the physicians who served in World War II. So far, these physicians have been represented only through the A.M.A. House of Delegates (average age 66 years) and through the House Medical Military Affairs Committee (which does not have **one** World War veteran).

If you want to take a part in this effort to stop the indiscriminate recall of medical veterans and to correct the iniquities of Public Law 779, organize a local chapter of the Medical Veterans' Society. Get in touch with the national secretary, David Curtis, M.D., 3101 Collingwood Boulevard, Toledo 10, Ohio. He will give you all the information you need.

There is no time to be lost.

These important messages may reach some of our readers too late to do much good. However, our Rocky Mountain region contains more than a thousand medical veterans of World War II. Every one of them should join the crusade to force the Pentagon and the Navy's Bureau of Medicine to wake up to the facts of life including modern medicine and plain ordinary truth.

In Colorado there has been organized the Physician Veterans' Association of Colorado, with offices at 214 Medical Center Building, Denver 6, Colorado. A letter stating its objectives has already gone out to veteran physicians of that state and a loyal response is anticipated. All of our states should act similarly, and rapidly.

Original Articles

SYPHILIS—COURSE AND MANAGEMENT*

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The unprecedented decline in reported cases of syphilis during the past five years is one of the important achievements of modern public health. Not only has there been a striking decrease in the incidence of early infections but mortality rates and admissions to mental hospitals attributed to syphilis have shown a marked decline. Much of this improvement in the control of a complex disease can be attributed to penicillin which surpasses all previous antisyphilitic agents in safety and rapid effectiveness. However, good treatment alone cannot be expected to control a chronic infection like syphilis without equally effective case finding. The latter is peculiarly difficult because syphilis, as a rule, causes minimal illness or discomfort until serious damage has occurred, usually many years after infection.

The fact that only 5 to 11 per cent of the total number of previously unreported cases of syphilis reported by the various states of this country in 1951 were in the primary or secondary stage is abundant proof of the difficulty of bringing early cases to medical attention. Even though some of the previously unreported cases in each state have actually had previous treatment, it is obvious that many early infections fail to be diagnosed. I doubt if this failure can be overcome in the near future because it is probable that from 20 to 30 per cent of individuals with early infections have no demonstrable lesions or such insignificant signs as to cause little concern to those who are careless about personal hygiene. Because of this probability case finding is a peculiarly difficult problem which taxes the ingenuity of those responsible for the control of the disease. That so much progress has been made in recent years is cause for congratulation but not reason for slackening efforts in case finding.

Theoretically, because of the rapidity and effectiveness of modern treatment, if all new infections could be found, syphilis would rapidly vanish. In some quarters it has already been called a vanishing disease, no longer deserving the serious attention of skilled medicine. Such complacency is premature. In continental U. S. A. in 1951 almost 200,000 previously unreported cases of syphilis were reported, of which over 18,000 were diagnosed in the primary and secondary stages. Thus, syphilis still ranks high in prevalence among communicable diseases. Furthermore, aids, such as immunization and sanitary measures used for the control of many infectious diseases, are not applicable to the control of syphilis. Under these circumstances, the time has not yet arrived when medicine can afford to neglect the diagnosis and treatment of an old and still puzzling disease. Actually, from the point of view of scientific medicine, no common infection is so baffling in its immunologic and pathologic aspects as syphilis. The disease provides a veritable museum of manifestations that cry aloud for explanations which have not been forthcoming.

In syphilis we have two major diseases—the acute and chronic stages—that differ immunologically and pathologically. The initial reaction of the body tissues to the Treponema pallidum produces acute lesions that are not only self-limited but also non-destructive; they heal without scar tissue and cause no permanent damage. Following the healing of acute lesions, probably within an outside limit of two years after infection, the tissues develop a very different reaction to the invading organism; either no demonstrable lesions can be found or we find chronic, destructive reactions

*From the Bellevue General Hospital, New York City. Presented before the annual meeting of the Wyoming State Medical Society, June 7, 1952.

that always heal with scar tissue. If the acute stage is completed without treatment, the body usually develops a permanent refractory state toward early lesions and, even though the late syphilis is cured and reinfection occurs, the tissues will react with chronic lesions or not at all. In other words, once the body has passed through the acute stage, with rare exceptions, it will never again react to the T. pallidum with early dark field positive lesions. If, however, the infected individual is treated at any time during the acute stage, relapse or reinfection may cause the redevelopment of early, acute lesions. During the acute stage, the spirochetes multiply and increase to tremendous numbers while in the chronic stage they are found with difficulty and apparently are actually present in small numbers, except in general paresis where they may occur in great abundance. The mechanism by which the body keeps the spirochetes few in number, yet fails to eliminate the infection, is unknown.

Some 60 per cent of individuals infected with syphilis escape serious injury throughout their lives. Possibly spontaneous cure occurs in some but in most asymptomatic late infections the T. pallidum probably survives as a relatively innocuous parasite during the life of the infected person. This probability is at least suggested by the fact that gummas may suddenly appear thirty or forty years after infection in patients who were previously asymptomatic during the chronic stage. In such cases postmortem examinations may show no pathologic signs of the long infection except for the scar of the gumma. In those who develop lesions of late syphilis, the pathologic processes may begin soon after the acute stage is completed or many years later.

In neurosyphilis and cardiovascular syphilis the pathologic reactions apparently occur early in the course of the chronic stage or not at all. This statement is certainly true of neurosyphilis because central nervous system reactions in syphilis are reflected in spinal fluid tests and, if these tests are normal four years after infection, they remain normal. We have no such tests for cardiovascular syphilis but from the abundant autopsy material of the past century, especially in Germany and Austria, we know that syphilitic changes have been observed in the aorta very early in the chronic stage of the disease, long before a diagnosis of aortitis could have been made in life. As a matter of fact the chronic syphilitic reactions that start early in the late stage progress so slowly that clinical signs and symptoms are rarely apparent for years. However, as previously stated, not all late lesions of syphilis start early in the chronic stage; the so-called gummatous reactions may occur at any time after the acute stage. They have been observed to develop from two to more than forty years after infection. Gummas have a relatively explosive onset and they usually make their presence felt quite rapidly. It is generally accepted that gummas are allergic reactions due to tissues that have become hypersensitive to the T. pallidum. Possibly all of the pathologic reactions in late syphilis are allergic in the sense that tissues will not react unless they have become sensitized to the T. pallidum and we may merely be seeing different types of such reactions. If so, no other single disease is associated with such a variety of inflammatory and degenerative changes as late syphilis.

As is well known, neurosyphilis is not only capable of producing a great variety of signs and symptoms but it also causes a variety of histologic reactions as observed at autopsies. The characteristic inflammatory reaction of syphilis is granulomatous, i.e., the cellular infiltration consists of lymphocytes, plasma cells and various other types of mononuclear cells rather than polymorphonuclear cells. Associated with the diffuse cellular infiltration there is a vasculitis and perivascular cuffing. This type of granulomatous reaction may occur in foci in various parts of the central nervous system or it may spread diffusely throughout the cerebral cortex as in general paresis. The cellular necrosis and atrophy associated with the reaction are secondary to the inflammatory changes and they are largely accounted for by anoxemia due to poor blood supply.

For reasons which remain entirely obscure degenerative processes occur in certain types of neurosyphilis in the absence

of any demonstrable inflammatory reaction. In tabes dorsalis, syphilitic spastic paraplegia and primary optic atrophy such degenerative changes are found in the posterior columns of the cord, lateral pyramidal tracts and optic nerves, respectively. Cellular infiltration is not observed and even a vasculitis is difficult to find. The process apparently begins with destruction of the myelin sheaths and its pathogenesis has puzzled pathologists for a century or more.

The foregoing phenomena are only some of the unsolved problems in acquired syphilis. For those interested in the relationship between immunology and developmental changes in the growing child we have the unexplained phenomenon of interstitial keratitis and the absence of cardiovascular involvement in congenital syphilis.

By now, however, I have surely reminded you enough of the complexities of syphilis to show that our understanding of this infection would in turn mean a far greater understanding of the biochemical and physiological reactions involved in immunology than we now possess. Osler's famous epigram that to know syphilis is to know medicine might be phrased, to understand syphilis is to understand immunology which includes the enormously complex mechanisms of body defenses that have been built up gradually by organisms since life began. Perhaps syphilis will have become a rare disease before that goal is reached. In the meantime is it not well to recognize that, even though syphilis is a venereal disease, now confined largely to the so-called lowest social and economic groups, it is still a fascinating scientific problem, worthy of the best brains in medicine?

Now that the foregoing lengthy introduction on what we don't know about syphilis has been completed, I will devote my remaining remarks to the more practical aspects of diagnosis and treatment. Here again we will encounter difficulties. With the exception of the seronegative primary stage, a past or present infection of syphilis can usually be diagnosed by serologic tests for syphilis (STS). These tests, however, do not solve the most important problem in the practical management of the disease which is to differentiate between active and inactive infections. No physician would consider treating inactive pulmonary tuberculosis with much scar tissue in the lungs in the same manner as an active case and the cardiologist always tries to differentiate between active and inactive rheumatic heart disease. A similar problem confronts us in syphilis. To deal with it as adequately as is possible we must separate the early, acute stage from the late stage. Let us first consider early syphilis before and after treatment.

Management of Untreated and Treated Early Syphilis

Untreated early syphilis is obviously active. Successful treatment is followed by rapid healing of lesions and marked drops in the titers of positive STS. Provided the patient remains asymptomatic following treatment and the STS titers have fallen to relatively low levels and, provided the spinal fluid examination is normal, we can assume the infection is inactive and probably cured. As a rule, we expect complete seronegativity within at least one year after treatment of primary and secondary syphilis and many physicians are disturbed when this does not occur. Experience has proved, however, that complete seronegativity cannot be expected in anything like 100 per cent of presumably cured secondary syphilis within one year after treatment. At Bellevue Hospital a recent review of over 2,000 patients treated for secondary syphilis with one of nine different schedules of penicillin and followed up with re-treatment for more than one year showed that 21 per cent were still seropositive one or more years after treatment. Most of the latter group become seronegative within the following year but some required from three to five years before becoming negative. They were not re-treated because we had previously learned that re-treatment had no effect on the STS after the titers had fallen to relatively low levels following treatment of secondary syphilis. Even when the STS titers fall but remain at relatively high levels re-treatment has little effect on the titers. In our recent review we found fifty-one patients who were re-

treated one or more times with large doses of penicillin or with intensive metal therapy because of seroresistance with relatively high STS titers (positive tests in dilutions of 1 to 4 or more) following treatment of secondary syphilis. When last examined from six months to five years after the first re-treatment, fifty of the fifty-one were still seropositive. In some cases doses as high as sixty million units of penicillin or six months of metal therapy had no apparent effect on the STS which behaved in very much the same way as the STS of patients who were not re-treated. None of these patients had any signs of syphilis; their spinal fluid examinations were normal, and, although one hesitates to speak of "cure" in such cases, we can certainly assume inactivity. From my experience, the categorical statement can be made that nothing is gained by continuing antisyphilitic treatment in such cases.

If, on the other hand, STS titers fail to drop following treatment of seropositive early syphilis, activity must be assumed. Such failures are rare but relapse, as demonstrated by a marked, sustained rise in STS titers following a previous fall, may occur as may reinfection. Most relapses of early syphilis have occurred within the first year after treatment and probably never more than two years after treatment. Reinfection, on the other hand, may occur at any time.

From our experience at Bellevue Hospital, the minimal treatment of primary syphilis that provides reasonably good results is a single injection of 1,200,000 units of procaine penicillin in oil and aluminum monostearate. A better dosage is two injections of 1,200,000 units on the same day or separated by one or two days. For secondary syphilis we advise no less than three injections of 1,200,000 units, with individual injections at two- or three-day intervals or even once a week if they cannot be given more frequently. In cases where lesions have been present for several weeks four or five injections of 1,200,000 units are to be preferred. The foregoing schedules of therapy are suggested as minimum dosages. The schedules, as given, are by no means mandatory and treatment can be arranged very much at the convenience of physician and patient, provided the total dosage for secondary syphilis is 3,600,000 units or more. It should be noted that the suggested schedules require the use of procaine penicillin in oil and aluminum monostearate. If procaine penicillin alone is used injections should be spaced at daily or two-day intervals because the penicillin is absorbed and excreted much more rapidly when aluminum monostearate is not added.

Management of Untreated and Treated Late Syphilis

Turning now to late syphilis, the differentiation between activity and inactivity in this stage is much more difficult than in early cases. In fact it is frequently impossible to make the differentiation accurately. In asymptomatic, latent syphilis where the diagnosis is made almost entirely on the basis of positive STS it is occasionally impossible to rule out biologic false-positive tests. The transitory false-positive tests that revert to negativity following some other illness than syphilis can usually be determined but false-positive tests that are persistent constitute a very difficult problem. The newly developed Treponemal immobilizing antibody test has proved helpful in distinguishing between true and false-positive STS but this test is still in the experimental stage and at present it is so complicated that it cannot be performed as a routine procedure. In general, the safest rule to follow is to treat previously untreated patients with persistently positive STS, although a definite diagnosis of syphilis should not be made when the patient's history suggests a possible false-positive test. Entirely apart from the possibility of biological false-positive tests, in asymptomatic late syphilis we have no means of knowing the degree of hidden pathology and, therefore, cannot distinguish between active and inactive injections. The STS titers prior to treatment are of little help in determining activity because patients may have low titers with very active syphilis.

Following treatment of late syphilis there is usually a gradual fall in STS titers that were relatively high before treatment but low titers at the time of treatment usually

change very little over a period of many years after treatment. Since individuals vary greatly in their ability to form reagin, the height of the blood STS titers is not a reliable guide to activity. In occasional cases it has been my experience that even high titers could not be changed appreciably by treatment. The persistence of activity after treatment in such cases is highly doubtful unless signs and symptoms prove that the disease is progressing. It must never be forgotten that STS are tests for a presumed antibody to syphilis and that antibodies of this kind in all probability continue to be formed long after their original cause has been removed.

In cases where gummas are visible or palpable the immediate effect of treatment is readily ascertained. Also the STS titers are usually high in patients with gummas and treatment usually causes a gradual but marked drop in titers over a period of one or more years. In cardiovascular syphilis, however, the STS titers may be low or high and we have no adequate means of differentiating between activity and inactivity. No treatment directed at killing spirochetes can be expected to restore a dilated aorta to normal size or correct aortic insufficiency. The infection may be cured or inactivated but the patient continues to have heart disease. How, then, are we to determine the amount of treatment believed to be needed for the inactivation of late syphilis? I can only answer this question by analogy with neurosyphilis where spinal fluid tests provide us with reasonable guides to the activity of the infection. Arguments by analogy are frequently dangerous but in this case it seems reasonable to believe that treatment capable of inactivating a very high percentage of active neurosyphilis should be adequate for most other types of late syphilis.

That spinal fluid examinations are a much more reliable guide to the activity of neurosyphilis than are the clinical signs and symptoms was first shown by Dattner who was associated with Wagner-Jauregg when the latter started treatment of general paresis with malaria. Dattner's conclusions have now been widely accepted. In general it can be stated that increased cell counts and/or increased total protein in the spinal fluid associated with positive specific tests for syphilis of the spinal fluid indicate activity. Inactivity is represented by normal cell counts and gradual improvement in quantitative specific tests for syphilis of the spinal fluid. Following treatment of active neurosyphilis, failure to inactivate the syphilitic process is shown by persistent pleocytosis and lack of improvement in other quantitative tests within six months after treatment or by a relapse to higher levels of spinal fluid tests that originally improved following treatment. As demonstrated by spinal fluid examinations, relapses of neurosyphilis rarely, if ever, occur more than two years after treatment. Neither Dattner nor I have observed a single relapse more than two years after treatment has produced inactivity. As in the case of early syphilis, most relapses of neurosyphilis occur within the first year after treatment.

It is always a temptation to blame syphilis for any or all of a patient's complaints if neurosyphilis was once diagnosed. Even good neurologists have overlooked brain tumors because of a positive spinal fluid Wassermann test. From my experience, little clinical improvement can be expected from treating a patient whose spinal fluid examination indicates an inactive syphilitic process. If, following treatment of neurosyphilis, the spinal fluid examinations show persistent inactivity of the syphilitic infection but the patient has developed new signs and symptoms, in all probability some other disease than syphilis accounts for the new clinical manifestations.

Abundant data have now appeared in the literature indicating that from six to ten million units of penicillin given over a period of fourteen to twenty days have arrested all types of active neurosyphilis, as determined by spinal fluid examinations, in at least 90 per cent of cases. Our present treatment of neurosyphilis at Bellevue Hospital is daily injections of 600,000 units of procaine penicillin in oil and aluminum monostearate for fifteen days in hospitalized patients and injections of 1,200,000 units three times a week for eight injections in the case of ambulatory patients.

By analogy with this treatment for neurosyphilis it would appear that 6,000,000 units of penicillin should be adequate for most cases of late latent syphilis and 9,000,000 units should be sufficient for cardiovascular syphilis although some authorities advise larger doses for the latter complication since we have no means of determining relapses of cardiovascular syphilis with any degree of accuracy. For relapse of neurosyphilis it is usually advisable to give from twelve to fifteen million units. In three cases at Bellevue Hospital we had to re-treat a third time with as much as thirty million units before persistent inactivation was obtained.

The foregoing brief review of the diagnosis of active syphilis necessarily omits discussion of unusual cases and exceptions to the rule which are bound to occur in almost any disease. My remarks have been directed to more or less routine diagnosis and treatment. In closing I might summarize the routine medical management of syphilis as follows:

1. Previously untreated cases of syphilis should be treated with penicillin.

2. Patients who have had previous treatment with irregular injections or undetermined amounts of metal therapy might well be re-treated with penicillin as a precautionary measure.

3. Relapses, as determined by STS, spinal fluid examinations or unquestioned clinical evidence, should be re-treated with higher doses of penicillin than those previously received. Only in rare cases will it be found necessary to resort to other antisyphilitic agents than penicillin unless the patient has become permanently sensitized to penicillin, in which case other antibiotics are to be preferred to arsenicals and bismuth.

4. Do not re-treat patients merely because of persistently positive STS. The continued presence of reagin in the serum of patients with well-treated syphilis is no more proof of an active infection than is a positive tuberculin test proof of active tuberculosis.

CHALLENGE OF CHRONIC DISEASE IN 1952*

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DENVER

As Chairman of your Committee on Chronic Disease, I wish to present a brief report to you concerning the challenge of chronic illness as it confronts us today. We feel that every doctor should be aware of the impending crisis that may face us because of the tremendously increasing incidence of debilitating maladies. For the sake of clarity, let me define what is meant by Chronic Disease. This definition is the one most acceptable to the authorities on this question.

Chronic disease comprises all impairments which have one or more of the following characteristics:

Are permanent.

Leave residual disability.

Are pathologically non-reversible.

Require special training of the patient for rehabilitation.

May be expected to require a long period of supervision, observation, or care.

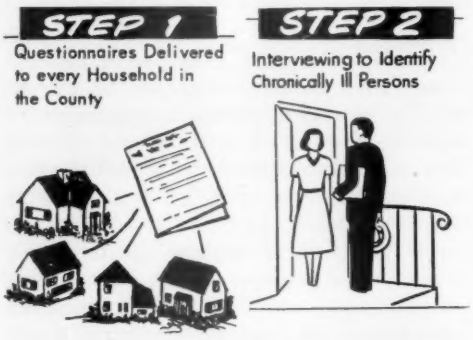
*Presented before 82nd annual session of Colorado State Medical Society, Estes Park, September 9-12, 1952.

Included among chronic disease are over 100 important disease entities. (Please note that from this definition we are dealing not necessarily with old age as such.) Statistics concerning chronic disease command our amazed respect. In the first place, although increasing age is a problem, one-half of chronically ill patients are below 45; one-sixth are under 25; and three-fourths are between 15 and 65, which years are, of course, the productive years.

In 1900, one-fifteenth of all deaths occurred from chronic illness. In 1950, over three-fourths of all deaths in the United States were similarly caused. Chronic disease affects every family. It is estimated that 25,000,000 people have a permanent malady in the United States today. Of these 25,000,000, 7,000,000 have disability exclusive of T.B.; 1,500,000 are invalids; chronic disease causes 1,000,000 deaths per year. One billion days of work are lost annually because of chronic illnesses. The cost is tremendous. A recent estimate prepared for

the President's Commission on Health Needs of the Nation includes the following statements: (1) Approximately $1,500,000,000 spent annually by public agencies on hospital, medical, and rehabilitation service for the chronically ill. (2) Approximately $1,500,000,000 in cash payments are made by public agencies to disabled persons. (3) Upwards of $150,000,000 is spent by private agencies other than hospitals and medical centers for a variety of services. These figures are startling, and alone should cause us to consider all democratic and reasonable ways to attack chronic disease.

Men of science have been largely responsible for adding years to life. It is surely a responsibility of science to add life to the years. Much has been accomplished already by the Commission on Chronic Illness to simplify the problem. This Commission, founded by the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association, and contributed to by many other state and private health organizations, has vigorously attacked the problem of the chronically ill since 1949. The Commission is composed of outstanding physicians, public health authorities, sociologists, and other prominent lay people. Its purpose is simply to find out how to prevent chronic disease.



In 1950, the Commission on Chronic Disease sponsored a conference on this subject attended by medical leaders throughout the country. At this conference, the myriads of problems presented were discussed in organized groups, and many aspects of prevention, detection, rehabilitation, and custodial care of the chronically ill were discussed. For detailed information, let me refer you to the report of the Conference on Chronic Disease which will be published this month.

Let us briefly discuss some important findings of the Conference. First of all, prevention is the most important aspect of the control of chronic disease. This goes without saying, and, of course, is easily understood by physicians.

Second, detection of chronic disease, although nebulous in its aspects, is certainly the responsibility of the practicing physician. The Commission feels that the physician must have the help of the detection facilities of screening for single and multiple diseases. An example of screening is the Tri-County Chest Survey in Colorado. The word "screening" is indeed a poor one, but there is not yet a better term. National Diabetic Week has provided another example of screening for glucosuria, and many other examples of screening immediately come to your mind and have been used in our detection of chronic disease.

Third, rehabilitation of the chronically ill has been vigorously promoted by many

federal agencies. In Colorado, the State Vocational Rehabilitation Program has, as you know, been excellent. Private organizations and voluntary agencies now serve the disabled perhaps more effectively than any. Examples of these include the National Association for Crippled Children and Adults, the National Foundation for Infantile Paralysis, and the National Tuberculosis Association, as well as at least ten other large organizations.

Last, a study of custodial care of the chronically ill, a final resort but a necessary one, has been undertaken by many who would render aid to the sick. The Commission finds in general that the care of the chronically ill in most cities is possibly progressing adequately, but most rural communities lack anywhere near adequate facilities. In carefully studying the needs of the chronically ill, the Commission has presented a plan whereby any community, rural or urban, may obtain the information it needs in caring for its own.*

CHRONIC ILLNESS -- comprises all impairments which have one or more of the following characteristics:
(1) are permanent
(2) leave residual disability
(3) are pathologically non-reversible
(4) require special training of the patient for rehabilitation
(5) may be expected to require a long period of supervision, observation, or care.

*Chronic Illness News Letter, Vol. 3, No. 5, 1952.

Step No. 1: Medical center volunteers will deliver a questionnaire to each household in a section or county. These questionnaires will gather facts about individual as well as over-all health needs.

Step No. 2: House-to-house interviewing follows up the questionnaire, where disabilities and defects resulting from accidents as well as illnesses, will be recorded. Facts gathered will include traces of all symptoms and disability, and enough information will be obtained to provide for classifying it under various headings in terms of disabilities, illness, hospitalized illness, illness for which medical care was received, diagnosis, etc. This interview will accomplish two things: The chronically ill will be identified, and the nature of illness and extent of disability will be estimated for each patient discovered.

Step No. 3 includes the checking of hospital or clinic records of interviewed patients for further information which will be acquired from the medical reports obtained from these hospitals.

Step No. 4: Evaluation by a medical team. A physician-nurse-social worker team will examine a good section—say 1,000—of the patients previously discovered. In this extensive, careful evaluation, all tests necessary to complete examination and definitive diagnosis will be available. The team will estimate the amount of care needed by each patient during a given period, including professional fees, and the cost of hospital or custodial care. A selected group must be representative of the general population, and will therefore form a basic index for the amount and type of services required by a key population.

Step No. 5: Multiple screening tests for several chronic diseases will be given to accurate cross-sections of the general population. Furthermore, a sample of patients whose tests indicate suspicion of disease will be given diagnostic examination to confirm or rule out suspicion of disease. This will help estimate the actual number of cases of disease to be found in a representative sample of population. All screening results will be sent to the physician named by the screened person.

You should know that this study outlined above is actually being undertaken in Hunterdon County in New Jersey. The Commonwealth Fund is financing the entire cost of the project, with personnel help from the Commission and the New Jersey State Health Department. Most important, school teachers, nurses, doctors, clergymen, and many other responsible volunteers are vital cogs in this all-community project.

This is a brief outline of what one community is doing to face the challenge of chronic disease. The results of this survey will be invaluable to other communities and within two years the world will know of Hunterdon County. Relatively few such surveys should be necessary to inform ourselves completely of the entire nation's needs. Let me again, however, stress the importance of all-community effort with a de-emphasis on Federal aid.

It is noteworthy for us to point out that in Colorado, groundwork surveys have already been made as late as August of this

year. A valuable report entitled "Colorado's Aging Population and Chronic Illness Problems" has been published by the State of Colorado Department of Public Health. With the knowledge contained in this carefully prepared report, Colorado can expect a considerable advance toward the meeting of our own needs.

Now what can we as individual doctors do about all this? First, a physician must interest himself and educate himself in the basic nature of the chronic disease problem. He must educate patients and interest them in preventing and controlling chronic disease. He must act as the primary detector of chronic disease whenever possible. He should, we are convinced, keep in close touch with the proceedings of the Committee on Chronic Disease in his component medical society and especially with the activities of our all-important National Commission on Chronic Illness. If the individual physician fails to do this, he will contribute signally to a failure on the part of American medicine to assume leadership in the solution of this vital problem. Bureaucracy has given us but a very few years in which we may formulate sound plans. If we fail to carry the ball, who knows what team will pick it up and run with it?

CARCINOMA OF THE PROSTATE*

SURGICAL TREATMENT

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When most of us think of carcinoma of the prostate we visualize an old man with a fatal disease. He cannot be cured anyway, so why not give him comfort and moderate life extension; and allow him to live out his limited life expectancy without too much disturbance or interference? None of the above assumptions is necessarily true. Cancer of the prostate is not necessarily an old man's disease. It appears occasionally in the late forties, is more common in the fifties, and the age of greatest incidence is between sixty and seventy. It is not necessarily incurable. Our low rate of cure is directly the result of late diagnosis and the failure to employ total removal of the prostate in early cases.

Palliative treatment does not always bring comfort or longer life. About 25 per cent of the cases are unresponsive to estrogens, others for various reasons will not tolerate them, and in the end estrogens tend to lose their effectiveness more or less completely anyway. Consequently, under these circumstances, we should concentrate our effort more upon early diagnosis and surgical removal.

Incidence

Cancer of the prostate is the commonest form of malignancy in men. It is commonly estimated that carcinoma of the prostate is present in 14 per cent of all men over forty-five, 18 per cent of all men in their fifties, and so on. Hinman[1] estimated that there are in the United States three to five and possibly eight million men with carcinoma of the prostate at the present time. If we agree that over half of the cases with prostatic obstructive symptoms eventually require operative relief, between 20 and 30 per cent of these prove to be of a malignant nature.

General Course

It may be desirable to review the course of this disease under various conditions and with various types of treatment. Huggins[2], of the University of Chicago, in reviewing 418 cases running a natural untreated course from first symptom to death, found them to average thirty-one months. Sixty-six per cent of those with metastases were dead in nine months, and of 273 cases without metastases only 10 per cent were alive after five years. Under estrogen treatment, including bilateral orchiectomy, 90 per cent received immediate benefit, but 75 per cent were dead in five years; 20 per cent lived eight years or more.

In a comparable series of seventy cases of my own treated between 1941 and 1946,

*Presented before the Forty-ninth Annual Session of the Wyoming State Medical Society, Lander, June 5, 1952.

with five-year follow-up data, 83 per cent were dead in five years. Of the remaining 13 per cent some were alive and still in remission at the end of seven to ten years.

In a group of cases with early malignancy treated by surgical removal, Huggins found 50 per cent to be alive and free of metastases after five years. In a similar group of thirty-two of my own, 70 per cent were alive two to eight years; ten, or 31 per cent, were dead, six of them from causes other than carcinoma.

Embryology and Pathology

Let us now turn for a moment to the embryologic development of the prostate as it is related to carcinoma. The prostate develops from two separate and distinct groups of glands. An inner rudimentary group arising from the floor of the uretha is responsible for the adenomatous hyperplasia in later life and this enlargement in turn compresses the remaining prostatic tissue peripherally against the fibrous capsule. This group of rudimentary glands is separated from the more complex glands of the true prostate by a thin fibrous layer of tissue. It is in the latter area that carcinoma arises.

Hypertrophy and malignant changes are independent processes. They may arise simultaneously or even multiple areas of malignancy may arise, about 75 per cent of which are located in the posterior lobe. Obstructive symptoms develop late in the disease. This has both favorable and unfavorable features from a diagnostic standpoint.

Malignancy arising as it does toward the periphery of the gland, the cortical portion or true prostate which has been compressed against the fibrous capsule is very accessible to rectal palpation. It is generally estimated that 85 per cent of all cancer of the prostate may be diagnosed by rectal palpation alone. The criteria for such a diagnosis are hardness or irregularity of the gland, assymetry, fixation to the pelvic fascia, vesicles, base of the bladder, uretha or rectum.

Symptoms and Diagnosis

Unfortunately the common symptoms of malignancy are usually associated with advanced pathology; hematuria, obstruction to urination, sacral or sciatic pain are all associated with advanced pathology. The earlier cases are almost always detected by rectal examination alone.

Besides rectal examination there are other diagnostic tests. The Papanicolau stain of expressed prostatic secretion is about 50 per cent accurate in early cases. It has the disadvantage of being negative as often as positive. The stain must be made by an expert and the results are subject to individual interpretation.

Another test, the blood acid phosphatase, is the only blood test for carcinoma. A normal level is under 1.5 King Armstrong units. Elevations of the determination occur only in carcinoma of prostate but usually with metastases or extension beyond the limits of the prostatic capsule. There are no false positives but approximately 54 per cent false negatives.

It is evident then that both of these tests are late diagnostic aids.

Biopsy of a suspected area of hardness in the gland if employed early, under the proper circumstances, is relatively accurate and, next to the actual pathologic examination of the prostate itself, is our most reliable diagnostic test. Perineal punch specimens, however, are of little value.

Frozen section after perineal exposure of the posterior aspect of the gland is practical and relatively reliable provided the proper area of the prostate is sectioned. Biopsy has the advantage of removing doubt as to the extent of the operation to be performed should it prove to be positive. However, a gland properly prepared for surgery by drainage and estrogens usually quickly loses its characteristic hardness and one must then rely upon his memory as to the location and extent of the malignant process in securing a specimen for examination. Results in my own hands have been approximately 75 per cent accurate, the same degree of accuracy as has been reported by Dean[3] at The Memorial Hospital in New York. As a result one cannot rely entirely on such findings.

I have had no personal experience with stained smears, obtained by suction through an 18-gauge needle and syringe. Dean is of the opinion such smears yield very accurate diagnostic results, although one must

be experienced in interpreting malignant cells in a stained smear.

It is thus seen that the diagnosis of early malignancy of the prostate is not an easy task. My own feeling is that in the proper age group any area of hardness persisting over several months' time, not associated with calcium deposits, or frank infection, should be assumed to be malignant and the gland totally removed, regardless of the frozen section biopsy report if such a test is employed. Few mistakes have resulted from this practice. If the gland later proves to be negative after removal (as occasionally happens) little if any harm has been done and the patient is satisfied. If the report is negative and the gland later proves to be malignant a fatal error has been made and no one is satisfied.

The proper preparation for surgery varies with the individual and with the extent of the suspected lesion. Customarily estrogens should be employed for from ten to thirty days prior to surgery. Seventy-five per cent of such glands will lose a portion or all of their characteristic hardness and with a short period of catheter drainage will diminish considerably in size, thus facilitating the operation to be employed. However, no estrogen treatment should be given until one has definitely decided on the presumptive diagnosis and upon the treatment to be instituted. One cannot with any accuracy reappraise the suspected prostate once such therapy is under way.

Whether one employs the retropubic or perineal route for removal of the gland depends on the operator's convictions and capabilities. The retropubic procedure is a longer, more extensive operation. Biopsy is not practicable and the mortality rate and morbidity are likely to be high. This procedure has been given up in some institutions, including that of Huggins. The perineal route is much easier on the patient, mortality is lower, the hospital stay shorter, there are fewer complications, and biopsy may be used if desired. Those opposed to it cite the technical hazards peculiar to it and the occasional failure to remove the vesicles completely. It is, however, the operation of choice by those familiar with perineal surgery.

Glands suitable for surgical removal are those in which there is an area of localized hardness, or the gland, although hard, is mobile. There should be no involvement of surrounding structures, no metastases by x-ray of lumbar and pelvic bones, a normal blood acid phosphate and the patient should be a good operative risk with a life expectancy of five years.

Cases falling into this category are gradually increasing. Collston[4], of Johns Hopkins, recently reports 22.7 per cent of all cases of carcinoma of prostate in that institution were being treated by total perineal prostatectomy. Kimbrough[5], at Walter Reed, reported 50 per cent of seventy-eight cases, and Gutierrez[6] 80 per cent. Some institutions, however, report from 0 to 5 per cent. Of the last 155 cases of my own, 19 per cent have been considered suitable for radical surgery and treated by total perineal prostatectomy.

The operative procedure is well tolerated by the patient; the average postoperative hospital stay has been fourteen to sixteen days. There has been but one mortality in forty-eight cases, approximately 2 per cent. Immediate postoperative complications have been few, with no persistent fistulae, no vesical neck strictures; and while there has been some degree of temporary incontinence in 50 per cent of the cases, the longest that incontinence has persisted has been four months.

A comparative appraisal of ultimate end results will require time. The immediate effect on the morale of the patient is excellent. Length of life in thirty-two cases operated upon before 1951 have been as follows: twenty-two cases alive two to eight years; ten dead, six from causes other than carcinoma. Recurrences when they have occurred have been non-obstructive in nature and the final terminal illness has been short.

Conclusion

The cure of carcinoma of the prostate, the commonest malignancy in men, still depends upon early detection and adequate surgery.

We have educational campaigns on a national scale to aid in the early recognition and treatment of many diseases, including

diabetes, heart disease in its various forms, various forms of malignancy, etc.

Carcinoma of the prostate, however, is unique in that no such comparable program is under way. Emphasis is still being placed upon various forms of palliative treatment, whereas our great need is for early detection and removal.

A careful rectal examination should be included in every general examination—this is particularly true of all men past forty-five.

Improvement in our rate of cure is largely in the hands of those of us who practice general medicine and in the education of the public to demand yearly routine examinations.

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NEW RISKS BRING NEW INSURANCE FORMS*

PART 2

L. ALLEN BECK, C.P.C.U.
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In the last issue of the Rocky Mountain Medical Journal appeared the first of two articles dealing with recent changes in insurance coverage that might be of interest to readers of this publication. The first dealt primarily with personal insurance—Fire, Theft, Liability, and the "All-Risks" forms, describing also the new "Homeowners Policy" which has been approved in Colorado and is submitted to the Insurance Commissioners of some of the other Rocky Mountain states for approval. It is proposed in this second article to touch, even more superficially, upon the forms of insurance needed to protect the professional activities of the physician and surgeon, and even more generally upon insurance coverages needed for businesses in which they may have invested some of their hard-earned fees.

Previous comments regarding the effect of inflation upon costs of replacement of property, and upon the need for greatly increased liability limits as a result of the trend by juries toward the awarding of higher judgments—these are probably even more important when considering protection for those operations and investments which enable one to build a personal estate. It is important that the insurance protection be in sound companies, and, of course, there is need to rely at all times upon the counsel of a competent insurance adviser.

Professional and Business Insurance

The business man can incorporate in order to separate business exposures from those that are strictly personal. But the doctor does not usually incorporate his professional operations, and it is therefore more difficult in his case to separate the personal from the professional or business, both as to analyzing the exposures and as to suggesting appropriate insurance coverages. We can distinguish, however, between Property Insurance and Liability Insurance, and we shall endeavor, therefore, to deal with these two general classifications in that order. One of these, Property Insurance, pays the policyholder for loss or damage to property—buildings, equipment, automobiles, money, etc. Liability Insurance protects against "third-party claims," claims made by others, alleging injuries to persons or damage to property arising out of the negligence of the insured or of an employee or agent acting on his behalf. In the case of a professional man it may go farther and protect against claims for alleged malpractice, error or mistake.

In discussing these business and professional risks and coverages, it is our intention to consider first the forms of coverage important to a business operation; and, fol-

*This is part two of a two-article series, the first of which appeared in the January, 1953, issue of the Rocky Mountain Medical Journal.

lowing this, those forms needed to protect the professional exposures.

Property Insurance

Protecting the Investment: The doctor who has invested in a mercantile building, clinic, hospital, ranch, a local drug store, or other business enterprise, will need to know that the attendant exposures have been carefully studied by an insuror thoroughly conversant with these risks and with the insurance coverages needed to protect his investment. It is not practical to attempt to discuss here all those forms of insurance which may be of greatest importance in any particular situation. This is the task for your insurance adviser. But we shall mention a few.

It may be expected that in insuring business property it may be advantageous to attach the 80, 90, or 100 per cent Coinsurance Clause, after first establishing dependable valuations; that provision will be made for insurance on Improvements and Betterments; that Leasehold, Rental or Business Interruption Insurance may be necessary in order to make certain that there is a continuing income to meet necessary expenses and to continue the normal rate of earnings following a fire or other insured catastrophe.

Power Plant Insurance may be needed when there is a steam boiler or refrigerating or other electrical machinery involved. Glass insurance may be required of a tenant under the provisions of his lease. If the operation is a substantial one, some form of Crime Insurance may be in order—the "3-D" policy, which pays for Dishonesty, Destruction and Disappearance, or a Blanket Bond and Broad Form Money and Securities policy. The small business may get by with one or more Fidelity Bonds and a limited form of burglary and robbery coverage.

Some form of Transportation Floater may be of value to concerns shipping merchandise in or out. A special form of policy to cover on Destruction of Records, and an Accounts Receivable policy may be needed to complete the program.

Office Coverages: It will be obvious to the professional man who has read thus far that many of the same insurance forms are needed to protect his professional operations. His furniture, fixtures, equipment, instruments, and supplies often represent a much greater investment than the contents of a business office of like size. And in many cases the rate of depreciation is much lower. It must be remembered that one should not confuse "book value" with "insurable value." The former usually represents the maximum annual depreciation allowable for tax purposes, while "insurable value" means cost of replacement at the time of loss, after deducting a rate of depreciation based upon the anticipated life of the particular item that has been lost or damaged.

For the physician or surgeon, a special broad form "Marine" policy is available to cover professional equipment customarily carried away from the office. This is known as "Physicians and Surgeons' Equipment Floater." The form includes loss by theft and may cover while in the hospital, in the automobile, in a patient's home, and elsewhere.

Whether or not the doctor owns the building in which his office is located, it may be desirable to carry Rent or Rental Value Insurance. If he has expensive laboratory equipment, a serious loss might cause him to go elsewhere for his laboratory work at greater cost for such services. In such cases it may be well to supplement this Rental with Extra Expense Insurance.

Even though the doctor may have the utmost confidence in his receptionist or technician, some form of Fidelity coverage is an inexpensive safeguard. Once such a requirement has been made, there can be no reasonable objection by new employees. Other Crime Coverages may seem necessary or not, depending upon the amounts of cash or checks involved and the distance to the bank.

Because of the present cost of automobiles and their repairs, the professional man will probably carry the customary forms of automobile physical damage insurance—comprehensive and deductible collision coverage.

The need for special protection against Destruction of Valuable Records should be

obvious to any doctor who has built up his practice over a period of years. And since it may be assumed that in the event of destruction of his bookkeeping records, not every patient will rush in to pay the account for which he has been previously billed, an Accounts Receivable policy may prove to be a life-saver in such a contingency.

If we are willing to concede that few men in the insurance business are qualified to diagnose their own physical ailments and prescribe for themselves, perhaps we may not seem too repetitious in suggesting from time to time in these articles that the wise professional man will select with care a competent insurance adviser and consult with him frequently as to the adequacy of his insurance program.

Liability Insurance

Protecting Business Risks: While the financial shock that can result through loss or damage to real and personal property is limited to the value of that property, or to the income which it may earn over a given period, it is not so easy to determine in advance the amount of loss that may be faced as a result of injuries caused to the person or property of others as a result of one's negligence.

The basis for all liability insurance is the old Common-Law Doctrine of Negligence, whereby one may be held responsible for a negligent act committed by himself or by his servant (employee or agent), causing injury to another. Such liability may be "Direct" or "Indirect," "Imposed by Law" (Legal Liability), or liability of others "Asusmed" under a lease or other agreement. For the business building or an office or store space rented, there is "O. L. & T." (Owners, Landlords and Tenants) Liability. Other situations may call for "M. & C." (Manufacturers and Contractors), "Products," "Completed Operations," "Contractual," "Independent Contractors" or "Protective Liability." These may now be combined in a "Comprehensive General Liability" policy, which, for a slight additional premium, affords automatic protection for other liability exposures that may arise during the policy term. Likewise, "Hired Car" and "Employees Non-Ownership Liability" may be included in the same policy with owned automobiles in a "Comprehensive Automobile Liability" form, and this may also be combined with the "Comprehensive General" in one contract.

There is needed, in addition, Workmen's Compensation Insurance in those states that have such statutory requirements.

If the mention of all of these forms of liability exposure seem somewhat confusing, it may serve to emphasize the importance of advising periodically with a competent insurance man who recognizes the area in which each of these forms is needed.

Professional Coverages: If a doctor has no liability exposures other than personal and professional, he may be adequately protected with an endorsement on his Comprehensive Personal Liability policy, extending it to include his office, in the same company. His personal and automobile liability coverage should be in the same company. If, however, he has any other interests, it is advisable that he have all of his liability coverage wrapped up in one package, a Comprehensive Liability form with the personal coverage added by endorsement. It is most important that all of his liability coverage wrapped up in one package—a disputes on claims as to which company pays.

In at least part of the Rocky Mountain states it is possible for an employer or one or two employees voluntarily to become subject to the Workmen's Compensation Act of his state, carrying insurance under the statutory form. By so doing he closes the door against common-law suits by disgruntled employees who have sustained some injury. Both the statutory Occupational Disease coverage, if available, and the Occupational Disease endorsement providing Employers Liability coverage for Occupational Disease disability not covered under the statute, add very little to the Workmen's Compensation cost.

In the preceding paragraphs we have discussed the liability exposures that may arise through the operation of a business or through ownership of property. The office of a physician or surgeon may have floors to which the janitor has applied wax a little too freely, a rug that could be poised for

tripping, a stairway that on this particular day is dangerously dark, or a sidewalk from which a busy doctor has not found time to remove the ice or snow. But a reasonable degree of care is required of occupants of such premises, and so you have an exposure to risk that may drag you into court.

Does the office girl ever drive a car belonging to another, when going to the bank or to a hospital? And does she first stop to inquire if it is insured? There are situations similar to these in which a doctor could wake up to find himself involved in a liability suit without even knowing that he had been exposed. And the Comprehensive form of Automobile Liability Insurance safeguards one against such unforeseen contingencies.

But, as all doctors realize, there is yet another form of liability which is of even more importance—a form now referred to as "Physicians', Surgeons', and Dentists' Professional Liability Insurance." It is, of course, most important that the doctor's liability exposures be protected by the appropriate forms of insurance coverage previously referred to; and, particularly if he has outside interests, that he call upon some competent insurance consultant to tailor one of the broad liability forms to fit his particular requirements. For with complications, he certainly would not attempt to prescribe for himself!

However, a physician or surgeon, because of the professional nature of his operations, is subject to claims by disgruntled patients because of injuries allegedly arising out of malpractice, error or mistake in rendering or failing to render professional services in the practice of his profession. And his entire future in his profession may be involved in the successful resistance of such claims, if not legitimate, or in their quiet settlement, if they prove to have merit. It is therefore of supreme importance that this coverage be carried in sound companies with experienced legal talent at their disposal; and that the insurance contracts be drawn to fit his exact professional situation. Such insurance should be carried in the same company that provides the personal or business liability for reasons given above.

Partnerships and Clinics

When a doctor is in partnership with another, it is necessary that each partner be protected for his own professional activities, but that the partnership be also protected, since any one partner might be sued for the acts of another. If there are employed physicians or surgeons or technicians, the doctor or doctors need protection as well. If a proprietor, or a partner in the ownership of a clinic, or if owner of stock in a clinic, hospital or other institutions with which he works, there are potential complications in the liability situation that call for serious study, and perhaps an opinion from the insurance company home office after submission of all the facts concerning the relationships.

If several interests are included in one policy, i.e., interests which are not exactly identical, it may be desirable to have attached to the liability contracts a "Cross Liability" endorsement. Without this, one of the insureds named in a policy might not be protected if injuries were sustained as a result of the acts of another party to the same contract. This is something that companies may be expected to provide if there seems to be justification for it. And such a situation could arise where there are subsidiary interests in connection with hospital or clinical operations.

High Limits a Necessity in Professional Liability

Twenty-five years ago or more, insurance companies found what seemed to be a solution to the then unfavorable trend in so-called "malpractice insurance" experience by limiting their acceptances to members in good standing of their County and State Medical Societies. Others were forced to pay much higher premiums to non-admitted companies for what sometimes proved to be protection that was of doubtful value. But through the years, inflation, liberality of juries, legal loopholes discovered by claimants' attorneys, an increased claim-mindedness on the part of the public, higher attorneys' fees and court costs—all these have contributed to the higher cost to the insurance carrier and the need for higher limits on the part of the physician and sur-

geon. Crowded waiting rooms also attest to the fact that most doctors are now working under greater pressure than heretofore; and that they are finding themselves called upon to render professional service to more and more people with whom they have no personal ties that might influence their reaction in case of some dissatisfaction with the doctor's services—or his bill!

Basic limits for Professional Liability are $5,000 per claim with an aggregate of $15,000 per policy per annum. But limits of $50,000/150,000 or even $100,000/300,000 are not at all out of line under present conditions.

The Routine Checkup

And in closing, there is one final recommendation—one that has been made repeatedly throughout this series of articles. It is a practice which, if followed by the public generally, might crowd the offices of our general practitioners and diagnosticians even more than at present, but which might avoid for that public many serious illnesses that could have been prevented or controlled. It is the idea of a routine checkup, and it is particularly appropriate in advance of any new venture. This final admonition, therefore, is to select with care your insurance adviser—consultant, agent, insuror. Let him understand that your insurance program is his responsibility. And then, as a professional man, call upon your professional insurance adviser regularly for a thorough checkup.

Book Review

Living With Cancer: By Edna Kaehele, 1952. Doubleday & Company, Inc., Garden City, New York. Price, $2.00.

Here is an excellent little book of 160 small pages, written by a 30-year-old woman who has cancer and is living with it. Even though it may some day be the cause of her death, she has learned the secret of living with this dread disease. She has gone through the stages of diagnosis, and its attending shock of reality; treatment, and its surprising lack of pain; the despair of learning that treatment has apparently failed; and then the realization that one can live with cancer.

She has learned the loss of fear from any other form of death; that fear of the unknown is worse than the suffering from pain; and that you should not look beyond the next twenty-four hours. Above all, it is important that you do something —not what you do.

I strongly recommend this book to those unfortunate people who know they have cancer.

A. LEE ALBERS.

Case Reports

CARCINOMA OR STONE IN THE COMMON BILE DUCT

A DIAGNOSTIC PROBLEM

CLAUDE F. DIXON, M.D., and SAMUEL P. McCARRAN, M.D.*
ROCHESTER, MINNESOTA

A physician, 65 years of age, retired from practice in 1948 because "it made him nervous and hypertensive." His father had died from heart disease, his mother from kidney trouble and one sister from tuberculosis. This patient was first examined at the Mayo Clinic on May 7, 1951, when his complaint was of trouble with his chest and vague pain in the epigastrium, especially in the right upper quadrant.

The first episode had occurred in the early part of 1950, had lasted about two hours, and had been followed by soreness across the upper right portion of the abdomen for two or three days. The second attack had come in October, 1950, preceding hospitalization for a tibial fracture, but the abdominal disturbance had continued to recur thereafter. It had consisted of steady, diffuse aching; there had been no colic, chills, nausea, vomiting or jaundice. The time of eating or the quality of the food had not influenced the pain but its severity had lessened when the quantity of ingested food had been small. Antacids had afforded relief but their use had been followed by "rumbling" of gas through the intestinal tract. Meanwhile, the patient's appetite had been good, his bowel had functioned regularly, and his stools and urine had been normal.

The patient was obese and weighed 200 pounds (90.7 kg.). Some edema of the left ankle was of traumatic origin. Roentgenographic study gave evidence that the gallbladder was not functioning. A diagnosis was made of cholecystitis with stone. The patient would not consent to surgical intervention. A diet compatible with reduction of weight and cholecystic disease was recommended.

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On May 16, 1951, the man had a "shaking" chill accompanied by severe, dull aching in the right upper abdominal quadrant and he was hospitalized. The right epigastrium was tender to pressure and the body temperature was 102° F. Leukocytes numbered 11,700 per cubic millimeter of blood. The value for serum amylase was 50 units (normal, less than 320 units) and that for serum lipase was 0.2 c.c. of tenth normal base per cubic centimeter. The sedimentation rate (Westergren) was 33 mm. in one hour. Antibiotics and a dietary regimen were prescribed.

Cholecystectomy was performed May 23. The gallbladder was small (contracted) but it did not contain calculi. The common duct was dilated to about two and a half times normal; no suggestion that calculi had formed within it was found and choledochotomy was not performed. The cystic duct and pancreas were of normal size although the latter was firmer than usual. The postoperative course was uneventful and the man was dismissed June 3.

The patient remained well until October, when he noticed occasional "grabbing" midepigastric pain of several minutes' duration which he attributed to dietary indiscretion. Occasionally he had episodes lasting as long as six hours, consisting of a tight, constricting sensation in the epigastrium accompanied by a feeling of "gas breaking loose." He was advised to employ phenobarbital, belladonna, or a proprietary spasmolytic agent,* but morphine was required for relief. The attacks occurred after meals and nocturnally and increased in frequency. Moreover, a bout of orchitis required hospitalization. Excretory urograms and roentgenographic studies of the colon and stomach, made during that period of hospitalization, gave negative results.

April 2, 1952, while the patient was working in his garden, he had severe pain in the right upper abdominal quadrant. The pain continued for six hours and the patient became nauseated and vomited several times. Following this episode his wife and brother observed that he was jaundiced. At this juncture, and while the patient still was jaundiced, he again reported for examination. The concentration of bilirubin per 100 c.c. of serum was 5.6 mg. direct and 1.8 mg. indirect. Values for amylase and lipase, reported on the bases explained before, were respectively 64 and 0.1. The prothrombin time (Quick) was 20 seconds. Thymol turbidity was recorded as 2 units (normal, 4). Leukocytes numbered 11,400 per cu. mm. of blood. The concentration of hemoglobin was 87 per cent. The duodenal drainage contained 50 c.c. of bile. An ordinary roentgenogram of the abdomen revealed only a ring-like shadow of calcification in the right upper abdominal quadrant; this was thought to be the shadow of a costochondral junction. Two possibilities posted pre-operatively were stone in the common duct or carcinoma of the ampulla of Vater.

At operation the common duct was found to be dilated to about five times normal. When the duct was opened, a large scoop passed easily into the duodenum. Palpation of the duodenum revealed, just proximal to the ampulla, a large stone which apparently had acted as a ball valve. The duodenum was opened and the stone, which was 1.5 cm. in diameter, was removed. Then choledochoduodenostomy (side-to-side anastomosis) was established, using the openings that had been made in the duodenum and the common duct. A specimen taken from the liver for microscopic study gave evidence of pericholangitis and periportal fibrosis, grade 2. The postoperative course was uneventful.

Comment

The laboratory findings in this case might easily lead to the strong suspicion of malignancy in the head of the pancreas. There was, however, marked inflammatory reaction in the duodenum, at the site where the stone was lodged, as well as around the ampulla of Vater, and there was a possibility of inflammatory narrowing in the region of distal portion of the common duct. Choledochoduodenostomy, therefore, was done and the patient was relieved. It would have been a disservice, in this case, if we had given an unfavorable prognosis and thus had encouraged the patient to forego further surgical intervention.

*Trasentine hydrochloride.

MATERNAL and CHILD HEALTH

TRANSPORTATION PROBLEMS IN PREMATURE INFANTS

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Colorado General Hospital

Since the greatest mortality in premature infants occurs in the first twenty-four hours of life, it may sometimes seem imperative to transfer these infants immediately to a nursery equipped for their care. This actually is not always the most desirable procedure. The following case illustrates how some of these decisions and difficulties may be handled:

Baby F., Hospital No. 49363, birth weight 1,162 grams (two pounds, nine ounces), was admitted to the Premature Infant Nursery at Colorado General Hospital at the age of twenty-two hours. He was born at twenty-nine weeks' gestation, following premature rupture of the membranes. The mother's four previous pregnancies were uncomplicated and at term.

The referring physician telephoned the Pediatric Department at Colorado General Hospital shortly after the onset of labor to request admission of the infant after birth. Immediate transportation for the baby was available, using a standard type incubator in an ambulance supplied with heat and oxygen. A registered nurse could accompany the baby and it was estimated that six to eight hours' driving time would be required. However, the advantage to the baby of having a day of rest following birth was discussed over the telephone, particularly since no feedings would be required and only close observation, heat and oxygen would be necessary. It was agreed to observe the baby overnight and plan for transportation the following morning.

The mother received vitamin K, prophylactic procaine penicillin and analgesia during labor, but was delivered without general anesthesia. Following gentle resuscitation of the baby with oxygen, he commenced normal breathing and was placed in a standard type incubator with continuous oxygen. Nothing was given by mouth, but vitamins C and K were administered intramuscularly.

Since on the following day the infant was vigorous and had maintained a good color, transfer seemed indicated because the degree of immaturity necessitated special medical and nursing care. Had this condition been poor, the risk of transportation would probably have been greater than that of continuing his care in the community hospital where he was born. The incubator was prepared by adding hot water bottles to keep the temperature between 80 and 90° F. in the heated ambulance. The bottles were refilled once during the trip when the incubator temperature began to fall. Oxygen was supplied continuously from a portable tank, under the nurse's supervision.

On admission to Colorado General Hospital, the baby's temperature was 350° C. (950° F.) rectally and he was found to be in good condition for his size. A special air-conditioned incubator was provided in which nursing care can be given without removing the infant. After eight hours, small feedings of 5 per cent glucose in water were begun by gavage, before trying a dilute half-skimmed milk feeding. Penicillin and streptomycin were administered because of the history of premature rupture of membranes. The remainder of the hospital course was not unusual for a baby of this size and he was discharged on the sixty-eighth day of life, weighing 2,630 grams (five pounds, 12½ ounces).

This case represents ideal circumstances for transportation of a small premature infant. However, the decision to transfer must always be individualized. The size of the infant, his general condition and the qualifications of the local hospital, as well as the experience of the personnel, must all contribute to this decision. Experience in Colorado is in agreement with that of Wallace, et al, in New York City[1] that it is usually best to avoid moving the baby for twenty-four hours after the shock of delivery. During this period it is unnecessary and inadvisable to feed a premature infant. Administration of oxygen in a heated incubator and careful observation are most important. Occasional suction is used, but handling should be reduced to a minimum. Vitamins C and K are given parenterally and antibiotics can be started if there has been evidence of exposure to infection, i.e., premature rupture of the membranes.

If transfer of a premature infant seems indicated, prior arrangements for his continued care should be made. The Colorado General Hospital requires that the referring physician approve the transportation plans for any infant accepted from a distant community. The most satisfactory device for transporting the premature baby is an incubator. Hot water bottles or other containers of warm water may be used to supply heat during the period that electrical connections are not available. Oxygen may be administered from a small tank. Either a physician or nurse should accompany the baby and be prepared to suction the nasopharynx, administer stimulants or carry out other procedures as necessary.

If an incubator is not available in the community, portable incubators supplied by the Colorado State Department of Public Health may be obtained on a loan basis. A premature infant ambulance is also provided and staffed by the Colorado General Hospital to pick up small babies within a radius of thirty-five miles of Denver.

Many of the larger premature infants, particularly those of 2,000 to 2,500 grams (four and one-half to five and one-half pounds) birth weight can be adequately cared for in community hospitals. In fact, most of these cases may go home with the mother in the same manner as full-term infants.

The limited number of premature infants who receive care in Colorado General Hospital provide clinical material for special training of physicians and nurses from Colorado and the Rocky Mountain area. The ultimate aim of Colorado's Premature Infant Program is to help the local hospital provide care for the majority of its premature infants.

REFERENCE

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NATIONAL AFFAIRS

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

The Sixth Annual Clinical Session of the American Medical Association was held in Denver, Colorado, December 2 to 5, 1952. The total registration was 7,635, of which number 2,862 were physicians and about 1,000 were nurses and medical students. We were favored with the usual Colorado weather—beautiful and continuous sunshine.

In the Journal of the American Medical Association of December 27, 1952, may be found an abstract of the proceedings of the House of Delegates, an editorial, "The Denver Meeting," and the monthly message of President Louis H. Bauer. Inasmuch as the Journal is available to all of our members, your delegates do not believe that a repetition of the material contained in the above mentioned reports is necessary.

December 1, 1952, was devoted to symposia on Public Relations. The continued interest in this important subject was attested to by the presence of large and attentive audiences. In a spirit of observation rather than of criticism, the thought emerges that there exists an undercurrent belief that to attain desirable public relations, we should mortify and castigate ourselves. We should tint our fingernails and display the deportment of a dancing master. It should be realized that public relations, as an activity, is synonymous with human relations: a two-way street requiring the practical application of the Golden Rule by all parties concerned.

President Bauer, in an excellent address, reviewed our problems and accomplishments. He emphasized the dangers of commercialism and recommended that "state associations be adamant in disciplining unethical members." He called attention to the nefarious program of the International Labor Organization. (The Bricker Resolution should receive our ardent support). He suggested that the requirements of the specialty boards be revised and that a committee of the House of Delegates meet with a Committee of the Advisory Board for Medical Specialties to "explore the situation" in order that prospective specialists might learn something of general practice and that general practitioners be given credit for general knowledge should they decide to specialize. It may be commented that the plethora of specialists, in considerable measure, is the result of public demand. People who bemoan the passing of "the good old family doctor" are among the first to demand a "specialist" when a wen on the neck or a thrombotic hemorrhoid appears. It is probable that many hundreds of capable physicians would have been contented to have remained general surgeons or general practitioners had they not grown weary of the unreasonable demands for "specialists." Hence, many of them became specialists. Some of them were trained and some were merely announced. This resulted, naturally and rightly, in the necessity for adequate preparation to practice a specialty. But specialism in medicine should not, like arteriosclerosis, begin in the cradle. Dr. Bauer is correct.

The meeting was opened by an eloquent invocation by Rabbi C. H. Kauver. It is humbly suggested that it be read as published in the Journal. Spiritual uplift is a welcome companion in this age of turmoil, strife and unrest.

Mrs. Ralph B. Eusden, national president of the Woman's Auxiliary, spoke for the 60,000 members of that organization. Aside from the moral support, the encouragement, and the inspiration which the Auxiliary has given us, it did these practical things in the past two years: donated $23,600 to the American Medical Education Foundation; plans another donation at the next annual meeting; contributed $600 to the World Medical Association; gave $500 to the Committee on Careers in Nursing; granted 171 scholarships and $26,187 in loans to nurses and medical students. Surely, the Woman's Auxiliary merits, and has, our deepest gratitude and appreciation.

Dr. Norman R. Booher, Vice Chairman of the National Rehabilitation Commission of the American Legion and a member of the American Medical Association, addressed the House as the representative of the Legion. It is noteworthy that Legion representatives speak, always, with friendship, frankness and fairness.

The reports of the Council on Medical Service, of the Council on Medical Education and Hospitals and of the Committee on Blood Banks should receive special attention.

The House of Delegates granted $500,000 to the American Medical Education Foundation, approved changes in the Constitution and By-Laws, deferred action on the "Doctor Draft Law" but expressed opposition to it, learned that 90,000,000 persons are protected by some form of voluntary health insurance, deferred action on Veterans' Administration affairs until the Bowes-Allen-Hamilton Survey can be studied, voted that membership in the International Organization be terminated, approved a resolution that an office of Secretary of Health be established with Cabinet status, recommended support of the Reed-Keogh Bills, elected Dr. John Mastin Travis of Jacksonville, Texas, as General Practitioner of the Year.

Much favorable comment was expressed regarding the excellence of the scientific programs, of the scientific exhibits, and of the adequacy of the Denver Auditorium. We are indebted, as usual, to our friendly and generous commercial exhibitors.

Your delegates are pleased to report that the officers of the American Medical Association and our colleagues in the House were profuse in their praise of every phase of the Denver meeting. And, in particular, of the efficiency of our Woman's Auxiliary.

GEORGE A. UNFUG,
WILLIAM H. HALLEY.

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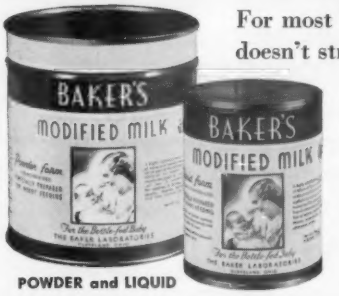

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COLORADO
State Medical Society

THE MOUNT AIRY FOUNDATION

The Mount Airy Foundation is unique in the hospital field. The corporation was recently formed by all the practicing psychiatrists of Denver to acquire the property of Mount Airy Sanitarium and to continue the operation of the institution for the treatment of nervous and emotional illnesses. Other objectives of the Foundation are the training of medical and associated personnel, the furtherance of research, and assistance to effective living among members of the community. Eventually there will be a program of financial assistance to medical students. The corporation is not for profit and no salaries or benefits will be paid to any of the trustees or directors. Profits will be applied to the purchase of the sanitarium and later to improvements and additions to the buildings and equipment. The transfer of the sanitarium to the Foundation is itself unique in that no immediate cash transaction was involved in the change of ownership.

Mount Airy Sanitarium was established in 1902 by Dr. Elvin J. Courtney, who named the sanitarium after his home town of Mount Airy, New Jersey. In 1911 the sanitarium was taken over by Dr. George Neuhaus, who was professor of psychiatry at the School of Medicine of the University of Colorado. The sanitarium was acquired by Dr. C. S. Bluemel in 1927. Three building programs in the past twenty-five years have enlarged the capacity of the sanitarium from thirty to eighty beds. The Foundation has plans for further additions in a few years.

The Board of Directors of the Mount Airy Foundation are Dr. John M. Lyon, President; Dr. Edward G. Billings, Vice President; Dr. Norbert L. Shere, Secretary-Treasurer; Dr. Robert Cohen, Dr. C. S. Bluemel.

The following psychiatrists are the Foundation's Trustees: Doctors Glaister H. Ashley, Clarke H. Barnacle, Edward G. Billings, C. S. Bluemel, R. Robert Cohen, Edward Delehanty, Jr., Franklin G. Ebaugh, Lawrence M. Fairchild, Charles G. Freed, Wray Gardner, John P. Hilton, Ira L. Howell, John M. Lyon, Philip May, Bradford J. Murphey, Aaron Paley, Charles A. Rymer, Norbert L. Shere, Clyde E. Stanfield, Leo V. Tepley, Warren H. Walker.

Obituaries

WILLIAM SIDNEY BAGOT, M.D.

Dr. Bagot was born in Rathmines Road, Dublin, Ireland, June 14, 1862, and died in Denver November 26, 1952, of uremia resulting from generalized arteriosclerosis. He acquired his general and medical education in Ireland, having received his medical degree in 1887.

Dr. Bagot practiced medicine in Dublin from 1887 to 1892, at the end of which time he came to Denver and began his specialty practice of general surgery, a field in which he achieved great distinction. He was elected to membership in the Denver County Medical Society in 1892 and was a member of the Colorado State Medical Society and the American Medical Association. Because of ill health he retired from active practice in 1925. He is survived by only an older brother in New York.

RALPH S. JOHNSTON, SR.

Dr. Ralph S. Johnston, Sr., who was President of the Colorado State Medical Society for the 1942-1943 year, died at his home in La Junta, Colorado, on December 3, 1952. Death was ascribed to a heart attack induced two days earlier when Dr. Johnston had lifted and carried a patient.

Dr. Johnston was born in Cedarville (now Cedar), Kansas, on January 4, 1887. After preliminary education near his home he attended Rush Medical School in Chicago and received his M.D. degree in 1912. He interned in the Kansas City General Hospital and then moved to La Junta, where he had practiced continually until his death. For two decades he was the surgeon in charge of the Santa Fe Hospital in La Junta.

Dr. Johnston had held every office in the Otero County Medical Society including its Presidency, and was a Fellow and active in the American College of Surgeons. His principal hobby was evidenced in his interest and support given to the Boy Scout movement in Southeastern Colorado. For many years before his election to the Presidency of the Colorado State Medical Society he had served on many scientific and civic committees of the Society and other organizations in the health field.

He is survived by Mrs. Johnston, a daughter, and two sons.

COLORADO
Medical School Notes

The appointment of Dr. Robert H. Alway as Professor and Head of the Department of Pediatrics at the University of Colorado School of Medicine was announced recently by Dr. Robert C. Lewis, Dean.

Since 1949, Dr. Alway has been Associate Professor of Pediatrics at Stanford University School of Medicine.

He received both his undergraduate and medical training at the University of Minnesota.

After receiving his M.D. degree in 1939, he interned at Jersey City Medical Center and took his residency at the University of Minnesota Medical Center.

He was on the faculty at the University of Utah School of Medicine from 1943-49.

Dr. Alway joined the University of Colorado School of Medicine faculty January 1. He replaced Dr. Harry H. Gordon, who is now at Sinai Hospital in Baltimore.

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THE SOUTHWEST ALLERGY FORUM

The Southwest Allergy Forum will meet at the Hotel Muehlebach, Kansas City, Missouri, June 14-15-16, 1953. The sessions are devoted primarily to papers on practical aspects of allergy. Those interested in participating in the program are invited to write the President, Dr. Orval Withers, Bryant Building, Kansas City 6, Missouri.

Members of the local committee are (besides Dr. Withers): Drs. Cecil Kohn, R. Dale Dickson, Frederic Speer, Stanley Goldman, Ralph Hale, Herbert Rinkel, and Vernon C. Wiksten.

Reservations should be made early at the Muehlebach. They may be cancelled if unforeseen circumstances prevent attendance.

For information write: Frederic Speer, M.D., Secretary-Treasurer, 2601 Parallel Avenue, Kansas City, Kansas.

Auxiliary

BOULDER COUNTY

At a dinner dance in December, held at the Boulder Country Club, Dr. Mason Morphit entertained with a hat full of magic tricks. Mrs. Bradford Murphey was a guest of the January meeting.

DENVER COUNTY

Orchids to Chairman Mrs. Byron Dumm, Assistant Mrs. Kenneth Sawyer, and their many efficient helpers for the fine job of organization for the March of Dimes Fashion Show, held in the Denver Theater on January 19. The Medical Auxiliary, together with several leading women's groups, are responsible for the show, for which five leading stores staged the finest fashion show that Denver has seen in years. A substantial sum was raised for the fund.

Mrs. Edward Delehanty, Jr., and Mrs. McKinley Phelps devote one morning each week to the Harry H. Field Memorial Clinic as representatives of the Denver County Auxiliary.

On January 26 the Auxiliary held its annual Laity Day meeting. They were host to the Health Chairmen of the P.T.A. Associations of every public, parochial, and private school in the city. The purpose: To acquaint the guests with the various projects such as Nurse Recruiting, Health, etc.

At the Stock Show the "You Can Reduce" exhibit, sponsored by the State Medical Society, is drawing interested crowds. There is a lighted calory chart, weighing machines, etc. This is part of the public relations and health education program. The booth is being staffed by Mesdames Grow, Wood, Woolgast, Akers, Delehanty, Jr., Kafka, Rettberg, Lawrence Brown, Buchanan, Ambler, Milligan, and Liggett.

EL PASO COUNTY

On December 10 Mrs. E. F. Geever was hostess to a covered dish supper for the Auxiliary members. There was a discussion of cerebral palsy and a book review by Mrs. Draper.

Mrs. Richard Vanderhoof entertained the Auxiliary on January 8 with a dessert party. Civil defense movies and a talk were given by Capt. Hugo Fischer.

A dessert meeting was held on February 12, with Mrs. Newton Faucett as hostess, assisted by Mesdames Bolton, Williams, and Draper.

MORGAN COUNTY

Mrs. Paul R. Hildebrand of Brush gave the Society an interesting and detailed report of the organization and activities of Handi-camp. She was empowered by the Society to make recommendations of deserving children to the committee in charge of selection of individuals to attend Handi-camp.

Mrs. Paul E. Woodward of Fort Morgan is a nurse in the Fort Morgan Public Schools and is the Auxiliary's chairman in charge of nurse recruitment activities. Mrs. Woodward arranged a display of posters on the advantages of a nursing career and personally conducted a group of nine senior girls on a tour of Denver hospitals associated with the University of Denver School of Nursing. Mrs. Woodward is vitally interested in this field and is a year-round enthusiastic worker. She is also active in the Morgan County work with crippled children and is the Society's representative.

A nursing career scholarship in the amount of $100 was established by the Auxiliary to be made up by individual contributions from the Society members. Mrs. C. F. Eakins of Brush and Mrs. Paul E. Woodward of Fort Morgan were appointed to administer the fund.

In the field of accident prevention, Mrs. L. C. Lusby of Brush and Mrs. W. J. Mellinger of Fort Morgan distributed posters for display by merchants in their respective towns, secured the cooperation of newspapers in printing articles on safety in the local papers and offered the use of movies on the subject to local organizations.

Mrs. Frank E. Roark of Fort Morgan was appointed to present to W. H. Lambreth, Assistant State Highway Engineer, the opinion of the Society that something should be done to eradicate a dangerous curve on the highway west of Fort Morgan, Mr. Lambreth replied that nothing could be done until it was determined whether or not the highway would be rerouted.

The Auxiliary proposed that the Morgan County Medical Society sponsor a plan to make preschool immunization compulsory by law.

Mrs. James Price of Brush as Civil Defense Chairman offered the services of the Society to Neil MacNeil, County Civil Defense Chairman. Each member registered individually with Mr. MacNeil to serve in the capacity where her training would be of most service.

The essay contest sponsored by the A.M.A. is to be brought to the attention of school children of Morgan County through the efforts of the Auxiliary's chairman, Mrs. R. B. Richards, in cooperation with the County Superintendent of Schools.

PUEBLO COUNTY

The following four-point program has been adopted:

1. Support of curative work shop. Rides for crippled children from their homes to work shop for post-polio treatments.

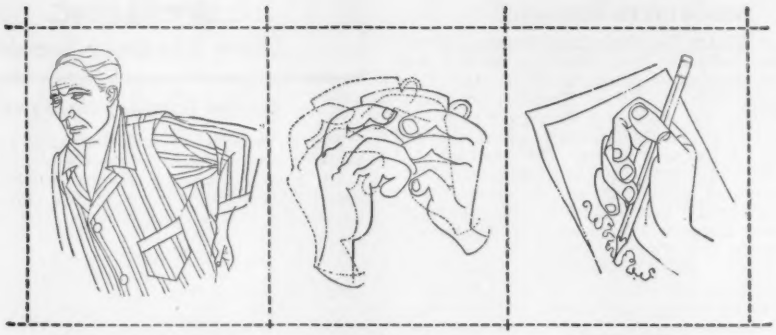
2. Support for nurse recruitment. Establishment of Nurse Clubs in high schools, annual tea, etc.

3. $2,50.00 is the goal for the Nurses Scholarship Fund this year.

4. Consistent sewing program for the three hospitals.

On January 21 the chapter is sponsoring the Style Show for the Polio Fund.

new uniform oral dosage



in muscle spasm of rheumatic disorders | **in acute alcoholism** | **in certain neurologic disorders**

The new, uniform oral dose for adults is 1-3 grams. This may be repeated 3-5 times per day.

The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink ⅓ glass of milk or fruit juice.

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For the Pueblo Medical Society's Spring Clinic, held January 8 and 9, the Auxiliary handled the registration for both days. In addition they provided social functions for the out-of-town wives.

SAN JUAN COUNTY

At a summer meeting, the Durango chapter decided to pay the tuition of a young Spanish girl attending the Nurses School in Boulder.

MID-WINTER MEETING

The Mid-Winter Meeting of the Woman's Auxiliary to the Colorado State Medical Society will be held in the Denver Country Club, East First Avenue and Franklin Street, Denver, on Thursday, February 19, 1953. All Auxiliary members are eligible to attend this meeting, and it is hoped that many of you will do so. The meeting will begin at 9:30 promptly with Mrs. Bradford Murphey, President, presiding, and will adjourn at 12:00 o'clock noon. Luncheon will follow at 12:30. Dr. William Liggett, President of the Colorado State Medical Society, and Dr. Ervin Hinds, Dr. Bernard Daniels and Dr. Joseph Freeman, members of our Advisory Council, will be our guests.

Members may register at the Shirley-Savoy Hotel on Wednesday, February 18, from 10 a.m. until 3 p.m. and at the Denver Country Club on Thursday morning. Luncheon tickets may be purchased at either place and members-at-large may pay their dues at this time.

The dinner dance, sponsored by the Woman's Auxiliary, will be held in the Shirley-Savoy Hotel on Thursday, February 19, at 7:30 p.m. Tickets will be $6.00 per person and formal dress will be optional. The cocktail bar will be open from 6:30 until 7:30 p.m. Music for dancing will be furnished by Milton Shrednick and his orchestra and both Viennese waltz music and modern dance music will be included in his program.

A suite of rooms—numbers 154 and 155—in the Shirley-Savoy Hotel will be available all day Thursday for the use of the out-of-town Auxiliary members. Transportation to the Board Meeting at the Denver Country Club will be provided for out-of-town members if they will call Mrs. Harry Whitaker EA. 0125, before 9 a.m. on Thursday morning.

FIRST WORLD CONGRESS ON FERTILITY AND STERILITY

The First World Congress on Fertility and Sterility will be held on May 25-31, 1953, at the Henry Hudson Hotel in New York City. This Congress is sponsored by the International Fertility Association with the cooperation of the American Society for the Study of Sterility.

Twenty-three scientific sessions are to be held, which will embrace the entire field of fertility and sterility, including sessions dealing with socio-economic factors, psychosomatic aspects, and artificial insemination. The sessions will be conducted in English, French and Spanish, with the use of earphones and simultaneous translations, as in the United Nations meetings.

In addition to the scientific sessions there will be medical round table discussions, questions and answer periods, scientific exhibits and motion pictures.

It is anticipated that 1,800 scientists from fifty-one countries will attend the Congress, making it the world's largest medical meeting devoted to problems of reproduction. This Congress will facilitate the exchange of ideas and information among doctors from the various countries, dealing with the very latest findings in fertility studies.

Since seats at the Congress will be at a premium, it is suggested that those who plan to attend write as soon as possible to the Chairman of the Local Arrangements Committee, 1160 Fifth Avenue, New York 29, New York, for advance registration.

WYOMING
State Medical Society

MALPRACTICE INSURANCE

The U. S. Fidelity and Guaranty master malpractice group insurance policy of the Wyoming State Medical Society will be cancelled July 1, 1954. In the future all insurance companies will issue only individual policies. This notice was received by the Executive Secretary's office. All individual physicians' policies expiring on or after January 1, 1953, will be renewed on the individual policy form only.

The U. S. Fidelity & Guaranty Company pointed out that by cancelling master policies all companies could effect a standardization of contract rates and benefits, though the new rates will be somewhat higher.

Each individual physician in Wyoming is urged to contact his own insurance agent and obtain malpractice insurance in the amounts and with provisions fitted to his own needs.

ANNUAL MEETING SET

The fiftieth annual session of the Wyoming State Medical Society will be held in Casper June 11, 12 and 13. Local arrangements are not complete but this and the scientific program will be announced at a later date. Put this on your calendar and plan to be present for this golden anniversary session. Your participation in the affairs of the Society are important.

COUNCILORS MEET

The Councilors of the Wyoming State Medical Society met at the Plains Hotel in Cheyenne January 18, 1953. Presiding at the meeting was Dr. Earl Whedon, Sheridan, Wyoming. Other councilors present included Dr. Paul Holtz, Lander, Wyoming; Dr. DeWitt Dominick, Cody, Wyoming (also a member of the state Senate, now in session); Dr. George Phelps, Cheyenne. Ex-officio members present were Dr. E. J. Guilfoyle, President of the Society, Newcastle, and Dr. Glenn W. Koford, Secretary, Cheyenne. Others present included Dr. James Sampson, President-elect of the Society, Sheridan; Dr. B. J. Sullivan, Vice President, Laramie; Mr. Arthur Abbey, Executive Secretary, Cheyenne, and Dr. Franklin D. Yoder, Scientific Editor, Cheyenne.

The Council considered and acted on matters concerning the Wyoming State Medical Society for which it acts between annual sessions. A portion of the discussion was concerned with matters of legislation.

The "Dr. Tim" radio series has now started its thirteen-week program in Cheyenne. It will soon begin its round of appearances in other portions of the state.

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UTAH
State Medical Association

REPORT OF THE UTAH STATE MEDICAL AUXILIARY FOR JANUARY, 1953

Although no general meeting of the Utah State Medical Auxiliary has been held since September, the component parts, the County Auxiliaries, have carried on intensive programs. A report from the oldest and largest of these would be that of Salt Lake County.

Salt Lake County Auxiliary gave countless hours in various ways before the political campaign. The October meeting was taken over by the Public Relations Committee to acquaint the members with the various political candidates. A Christmas luncheon and program was held on December 1 at the Ladies Literary Clubhouse at which Dr. David Shand and a university chorus furnished the music for the day. Beginning with January the Auxiliary will devote several meetings to the Nurse Recruitment Program. They are also collecting old muslin sheets and pillow cases for the Cancer Society and will assist this society in making dressings.

Utah County Auxiliary was host to the Utah County Dental Auxiliary in November. Mr. Faye Evans of the Second District Juvenile Court of the State of Utah gave an interesting talk on "The Cause for Delinquency in Our Youth Today."

Weber County Auxiliary began their year's work with a Fashion Show—Fashions Then and Now. Money raised was to be used for nurse scholarships in several hospitals. This is an annual affair with the Weber County ladies. Auxiliary members worked hard to help get out a record vote in Weber County, Davis County and Boxelder. They were responsible for addressing and mailing over 14,000 letters, pamphlets and cards concerning election data, beside telephoning most persons listed in the telephone directory, asking them to get out and vote. Several members spent all election day picking up ballots for hospitalized patients, having them notarized and returning them to the polls. Many members acted as chauffeurs and baby sitters for those needing such services, as well as serving as judges, checkers, and watchers at the polls. In November, at a luncheon on the roof of the Hotel Ben Lomond, Dr. William Stratford gave a very informative talk on Communism. In December, the Weber County Auxiliary held its Christmas party in the nurses' home of St. Benedict's Hospital, where a delightful program was given, and followed by the presentation of nursing scholarships. These were accepted by the supervisors from the Thomas Dee Memorial Hospital and St. Benedict's Hospital. State officers were special guests.

Carbon County began its money-raising program with a Golf Tournament, which proved not only to be a good money-maker, but provided plenty of fun to the participants. Over $100 was cleared. This money is earmarked for the Nurse Recruitment Program.

Mention should be made of two of the officers of the Utah State Medical Auxiliary who have carried on the affairs of the state in every way, yet took a few days off to have additions to the family. The State President, Mrs. Vernal Johnson, had a baby girl on November 18, and the Recording Secretary, Mrs. Thomas Feeney, had a baby girl on September 5. Mrs. Vernal Johnson entertained her Executive Board at a luncheon at her home on December 4, baby and all. In the future it would seem that motherhood is no excuse for not being able to serve the State Auxiliary.

MRS. CLAUDE L. SHIELDS,
Publicity Chairman.

The Book Corner

New Books Received

Disorders of the Circulatory System: New York Academy of Medicine; Edited by Robert L. Craig, M.D.; A Symposium presented at the Twenty-fourth Graduate Fortnight of the New York Academy of Medicine, October 8 to 19, 1951. The MacMillan Company, New York, 1952. Price, $5.50.

Advances in Internal Medicine: Editors, William Dock, M.D., Long Island College of Medicine, Brooklyn, and I. Snapper, M.D., The Mount Sinai Hospital, New York; Volume V. The Year Book Publishers, Inc., 1952.

The History of American Epidemiology: By C. E. A. Winslow, Dr. P.H., Professor Emeritus, Yale University School of Medicine; Editor, American Journal of Public Health; Wilson G. Smillie, M.D., Professor and Chairman, Department of Public Health and Preventive Medicine, Cornell University Medical College; James A. Doull, M.D., Medical Director, Leonard Wood Memorial (American Leprosy Foundation), and John E. Gordon, M.D., Professor and Chairman, Department of Epidemiology, School of Public Health, Harvard University. Edited by Franklin H. Top, M.D., Professor of Epidemiology and Pediatrics, College of Medical Science, University of Minnestota. Sponsored by The Epidemiology Section, American Public Health Association. St. Louis: The C. V. Mosby Company, 1952. Price, $4.75.

Textbook of Physiology: By William D. Zoethout, Ph.D., Professor Emeritus of Physiology in the Chicago College of Dental Surgery (Loyola University); and W. W. Tuttle, Ph.D., Professor of Physiology, College of Medicine, State University of Iowa. Eleventh Edition, with 302 Text Illustrations and five Color Plates. St. Louis: The C. V. Mosby Company, 1952. Price, $4.75.

Brain Surgeon: The Autobiography of William Sharpe. The Viking Press, New York, 1952. Price, $3.75.

Correlative Neuroanatomy and Functional Neurology: By Joseph J. McDonald, M.S., M.Sc.D., M.D., Professor of Surgery, Columbia University; Attending Surgeon, Presbyterian Hospital, New York; Director of the Surgical Service, Francis Delafield Hospital, New York. Joseph G. Chusid, A.B., M.D., Attending Neurologist, St. Vincent's Hospital, New York. Sixth edition. Lange Medical Publications, University Medical Publishers, P.O. Box 1215, Los Altos, California. Price, $4.00.

Symposium on Treatment of Trauma in the Armed Forces: Sponsored jointly by The Division of Medical Sciences of the National Research Council and the Army Medical Service Graduate School, Walter Reed Army Medical Center. 10-12 March, 1952. Army Medical Service Graduate School, Washington 12, D. C.

The Literature on Streptomycin 1944-1952: By Selma A. Waksman. Rutgers University Press, New Brunswick, New Jersey, 1952. Price, $5.00.

Rheumatic Diseases—Diagnosis and Treatment: By Eugene F. Traut, M.D., F.A.C.P., Associate (Rush) Clinical Professor of Medicine, University of Illinois; Attending Physician to the Cook County Hospital and to the West Suburban Hospital, Oak Park, Illinois; Associate Attending Physician to the Presbyterian Hospital of Chicago; Director of the Arthritis Clinic of Cook County Hospital; Lecturer on Arthritis in the Cook County Graduate School of Medicine; Member of the American Rheumatism Association. With 192 illustrations. St. Louis: The C. V. Mosby Co., 1952. Price, $20.00.

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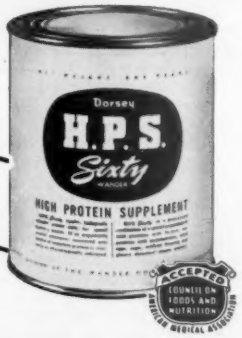

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The Low Fat Diet Cook Book: By Dorothy Myers Hildreth, Dietitian, and Eugene A. Hildreth, M.D.; Introduction by Francis C. Wood, M.D. Medical Research Press, New York; distributed by Grosset & Dunlap, 1952. Price, $2.95.

Cornell Conferences on Therapy, Volume V: Edited by Harold Gold, M.D., Managing Editor; David P. Barr, M.D.; Frank C. Ferguson, Jr., M.D.; McKeen Cattell, M.D.; Frank Glenn, M.D.; George Reader, M.D. New York: The MacMillan Company, 1952. Price, $4.00.

Book Reviews

Clinical and Roentgenologic Evaluation of the Pelvis in Obstetrics: By Howard C. Moloy, M.D., M.Sc.; Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons, Columbia University, and the Sloane Hospital for Women. W. B. Saunders Company, Philadelphia and London.

In this monograph Doctor Moloy has presented in a summary form a large amount of data concerning cephalo-pelvic disproportion. Some clarification of pelvic morphology is accomplished by his concise presentation accompanied by good diagrams and drawings. His comprehensive clinical examination of the pelvis is a stimulus to more complete evaluation by easily attainable means. Forceps mechanisms as related to pelvic type add an interesting feature. He presents a technic and method of evaluation useful and adequate in roentgenologic examination of the pelvis. The importance of the pelvic diameters and pelvic shape with a knowledge of their relationship to the outcome of labor is stressed. Doctor Moloy has taken the many measurable factors, filtered them by prolonged experience and presented them in his monograph as an aid to the student in understanding this complex subject.

W. F. MANLY, M.D.

Clinical Allergy: A Practical Guide to Diagnosis and Treatment: By Samuel J. Taub, M.D., F.A.C.P., Professor of Medicine and Chairman of the Department of Allergic Diseases, the Chicago Medical School; Professor of Medicine, Cook County, Columbus, and Mt. Sinai Hospitals. Second Edition, Revised and Reset. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers.

As the author states in his subtitle Clinical Allergy is an intensely practical guide to the diagnosis and treatment of allergic disorders. The author has recognized the need for a book such as this, not for the specialist, but for the general practitioner who still sees and treats the bulk of allergic complaints. After a rather brief summary of theoretical considerations, the author launches into a consideration of the various allergic disorders, and maintains a practical approach throughout. In every chapter, many case records are quoted from Dr. Taub's own extensive experience. Controversial issues are avoided, the author preferring to cite his own method of handling the various problems. One of the most useful portions of the book is the appendix, some 40 pages. In this section Dr. Taub has listed the various plants and their locations, pollenation schedules, common inhalant, ingestant, and contact allergens, ingredients of common foods, special diets and recipes, and common cosmetic irritants and allergens. This section alone is worth the price of the entire book, because of its intensely practical value.

On the negative side, one may state that while research work as well as opinions of authorities are constantly discussed, few authors are mentioned by name, and the book lacks a bibliography. However, it has become fashionable recently in monographs which are practical to eliminate all unnecessary verbiage, and Dr. Taub has done this exactly. Another criticism, this more serious, is the total absence of illustrations in a book which is otherwise filled with practical points. This is most obvious in the section on skin testing where the GP needs help in performing and interpreting tests and results.

Other than these criticisms, Clinical Allergy is highly recommended as a well-rounded, easily readable, and intensely practical guide for the non-specialist in allergy who wants and needs more knowledge in this field.

ALLAN HURST, M.D.

Sex and the Law: By Morris Ploscowe. Prentice-Hall, Inc., New York.

"Sex and the Law," written by Judge Morris Ploscowe, is a fascinating survey of the legal aspects of some of our most pressing social problems. With the objectivity of the trained jurist, the judge highlights many basic human relationships against the background of history and precedent and in the light of modern sociological analysis such as the Kinsey report.

The antiquated state of many of our laws concerning marriage, inheritance, illegitimacy, divorce, adultery, rape, homosexuality and prostitution is evident even to the casual reader. The obvious need for modernizing legislation with regard to sexual criminals is clearly shown. The marked discrepancies between laws of the various states is shown clearly in that an act in one state is legal and in another state is a criminal offense.

One cannot read this book thoughtfully without wondering if true justice to society and to the individual is often attained.

SAM W. DOWNING, M.D.

Principles and Methods of Physical Diagnosis: By Simon S. Leopold, Associate Professor of Clinical Medicine, School of Medicine and Graduate School of Medicine, University of Pennsylvania; Director of the Teaching of Physical Diagnosis, School of Medicine; Chief of the Thoracic Clinic, Hospital of the University of Pennsylvania.

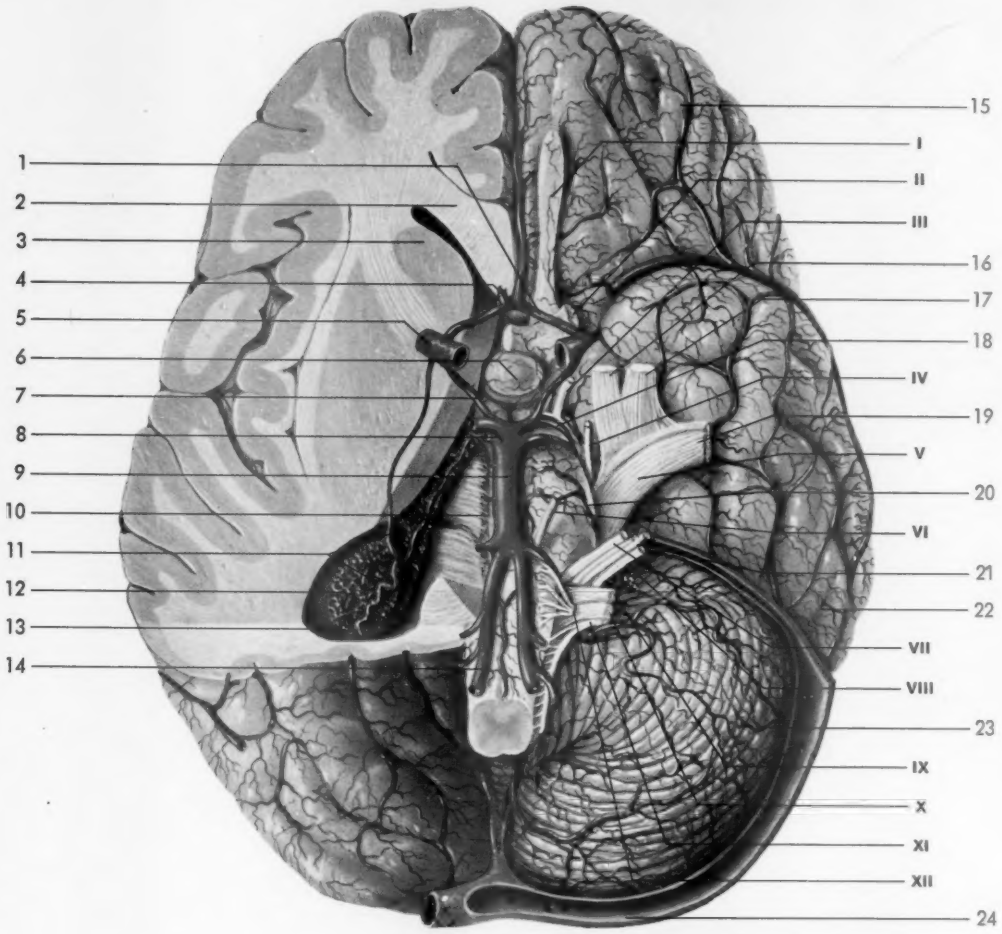
In his preface, the author emphasizes his belief that the principles and methods of physical diagnosis should be taught by correlating physical signs with physiological and pathological changes in disease. His well-illustrated and quite readable book exemplifies this belief.

Inspection, palpation, percussion, and auscultation are dealt with in a manner characteristic of most texts in this subject, but the author has enhanced the value of his book for the student by emphasizing special examinations often omitted from the treatise on physical diagnosis. For instance, an excellent chapter on muscle-testing is included, and the fundamentals of sigmoidoscopic and pelvic examinations are discussed. Simple instructions for proper draping of a patient for an examination may foster equanimity in the apprehensive student uninitiated in the art of examination.

A striking departure from the average text is the inclusion of a chapter on Acoustics by S. Reid Warren, Jr., Professor of Electrical Engineering at the University of Pennsylvania. His discussion of sound production, transmission, and perception, along with the physical properties of the ideal stethoscope, is interesting, and makes one wonder that any significant information can be obtained by auscultation in so complex a structure as the chest.

The author, in another chapter, quite properly emphasizes the complementary positions of radiological and physical examinations, one in no sense replacing the other.

Anatomy *of the* Brain



1. Anterior cerebral artery
2. Trunk of corpus callosum
3. Head of caudate nucleus
4. Anterior communicating artery
5. Middle cerebral artery
6. Hypophysis
7. Posterior communicating artery
8. Superior cerebellar artery
9. Basilar artery
10. Internal cerebral vein
11. Choroid artery and vein
12. Choroid plexus of lateral ventricle
13. Inferior cornu of lateral ventricle
14. Vertebral artery
15. Frontal lobe
16. Ophthalmic nerve
17. Maxillary nerve
18. Posterior cerebral artery
19. Mandibular nerve
20. Pons
21. Intermediate nerve
22. Temporal lobe
23. Cerebellum
24. Left transverse sinus

CRANIAL NERVES

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II. Optic nerve
III. Oculomotor nerve
IV. Trochlear nerve
V. Trigeminal nerve
VI. Abducens nerve
VII. Facial nerve
VIII. Acoustic nerve
IX. Glossopharyngeal nerve
X. Vagus nerve
XI. Accessory nerve
XII. Hypoglossal nerve

This is one of a series of paintings by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

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* * *

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A bibliography of 57 selected references will be mailed on request.

This book impresses me as being unusually good for the student just entering the clinical phase of medicine.

G. H. CURFMAN, JR., M.D.

Diabetes Control: By Edward L. Bortz, M.D., Chief of Medical Service B, The Lankenau Hospital; Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia; former President of the American Medical Association. Illustrated. Lea & Febiger, Philadelphia, 1951.

This rather small book has a wealth of information in it, and all of a practical nature. One very important aspect of the book is the plea for better diabetic control, and the author's reasons for insisting on such control.

Every aspect of diabetes is covered quite adequately, although some of the more complicated aspects of the disease are left out. The section on meal planning is exceptionally good, and one which I think everyone could use to advantage.

I would think this book would be exceptionally good as a quick reference book for anyone treating diabetes mellitus and some of its complications.

E. PAUL SHERIDAN, M.D.

The Management of Fractures, Dislocations and Sprains: By John Albert Key, B.S., M.D., Clinical Professor of Orthopaedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's, and Jewish Hospitals; and H. Earle Conewll, M.D., F.A.C.S., Associate Professor of Orthopaedic Surgery, University of Alabama School of Medicine; Chief of Orthopaedic Service, South Highland Infirmary; Consulting Orthopaedic Surgeon to Carraway Methodist Hospital and Baptist Hospitals; Attending Orthopaedic Surgeon, Children's Hospital, Jefferson-Hillman Hospital, East End Memorial Hospital, and St. Vincent's Hospital, Birmingham, Alabama. Fifth edition. Illustrated. The C. V. Mosby Company, St. Louis, 1951.

The publication of a fifth edition attests the popularity and value of this book. It is so well known that a "review" of this edition is hardly necessary. This book has been thoroughly revised and brings the reader abreast with the newest methods of treating fractures and dislocations.

BERNARD C. SHERBOK, M.D.

The Toxemias of Pregnancy: By William J. Dieckman. Second Edition; 710 pages. St. Louis, Mo.; C. V. Mosby Company, 1952. Price, $14.50.

The second edition of The Toxemias of Pregnancy lives up to its anticipated worth. Dr. W. J. Dieckman is as well qualified to write on the subject as any other man, having devoted a large portion of his life to its study.

He has continued to include the minute studies on this subject from every aspect which does tend to make it more valuable from the standpoint of the student of toxemias but more difficult to read and assimilate.

The classification, incidence and pathology of eclampsia comprise the beginning chapters. Normal and abnormal physiology of the body as related to pregnancy is covered in a thorough manner. The placenta is considered in relation to anatomy, physiology and pathology. The endocrine glands and their functions in relation to the toxemias of pregnancy are adequately presented. Edema is recognized as a temporary protective mechanism in pre-eclampsia. The brief summary of each chapter is a definite benefit to the casual reader.

The facts known about the etiology of eclampsia are of special interest to Dr. Dieckman who transmits this in force. The clinical aspects and

(Continued on Page 142)

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DR. GUY A. ASBAUGH has retired as general practitioner in Weld. Dry town, surrounding community of three towns with total population of 1,200. His house and office are for rent for $100 a month. For further information, call Frederick 2322, or write Box 9, Rocky Mountain Medical Journal, 835 Republic Building.

OPENING FOR EXPERIENCED general practitioner in Burlington, Colorado. Dry farming community, several other doctors in the town, 25-bed county hospital, community with population of about 2,500. For further information, contact Mr. Thornton H. Thomas, Jr., Box 447, Burlington, Colorado.

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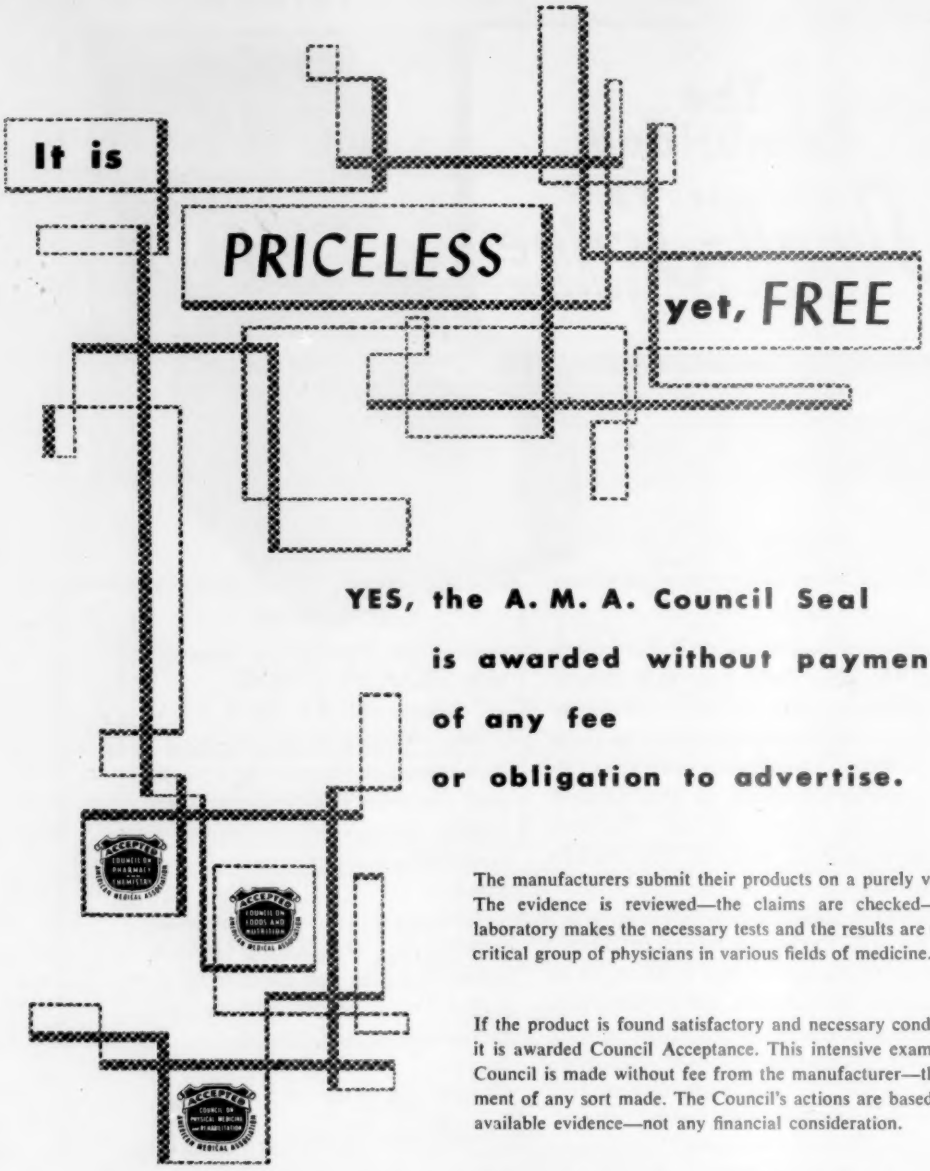

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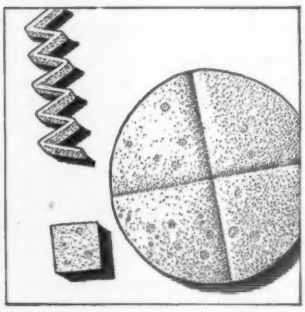

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From where I sit *by* Joe Marsh

Bunny's Story Had a Nice "Ring" to It

"Bunny" Baker—our cute blonde secretary over here at the newspaper—showed up late for work the other morning and "scooped" us all.

Bunny came in carrying a big box of cigars under her arm and, without a word, went around dropping a cigar off at each desk. Finally, when we were all but bursting with curiosity, Bunny told us what was going on. She held up her left hand and proudly displayed a lovely diamond ring on her third finger.

"It's a boy," she said. "Six feet two, a hundred ninety-six pounds."

From where I sit, Bunny's way of announcing her engagement showed real ingenuity. And ingenuity—doing things in a better and different way—is a typical American trait. Freedom of expression, freedom to work how and where we please . . . even a little thing like the freedom to choose a glass of beer after a day's work—these are some things that make our nation so "engaging."

Joe Marsh

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BOOK CORNER

(Continued From Page 137)

treatment of the toxemias are brought up to date. The complications of toxemia present themselves in ever-recurring surety. Prenatal care is shown to have decreased maternal and fetal morbidity and mortality due to toxemia of pregnancy, but the treatment at delivery is much more important.

G. T. FOUST, M.D.

The Unipolar Electrocardiogram — A Clinical Interpretation: By Joseph M. Barker, M.D., F.A.C.P., Cardiologist, Yater Clinic; Associate Professor of Clinical Medicine and Special Lecturer in Physiology, Georgetown University School of Medicine; Director of the Heart Station and Visiting Physician, Georgetown University Hospital; Chief of Cardiology, Providence Hospital; Visiting Physician, Gallinger Municipal Hospital; Consulting Cardiologist, Arlington Hospital, Arlington, Virginia. Assisted by Joseph J. Wallace, M.D., F.A.C.P. Advised by Wallace M. Yater, M.D., F.A.C.P. Foreward by Frank N. Wilson, M.D., F.A.C.P. Appleton-Century-Crofts, Inc., New York.

In recent years the book market has been flooded with new textbooks on electrocardiography, many of which have been inadequate. This book is an exception. It is the type of book that can be used equally well by the neophyte and the experienced electrocardiographer. The material is well organized and clearly presented. It is profusely illustrated. In places, it seems as though it could have been written in more concise fashion; but this is a minor criticism and in no way detracts from the general usefulness of the text. Moreover, since the author was trained by the late Frank N. Wilson, M.D., the viewpoints presented can be said to be representative of the Wilsonian school. The textbook includes discussions of basic electrophysiological principles, the electrical position of the heart, intra-ventricular block, myocardial infarction, transient myocardial ishemia and injury, ventricular hypertrophy, the arrhythmias and miscellaneous conditions. In the opinion of the reviewer, this is the best of the current textbooks of electrocardiography.

H. HAROLD FRIEDMAN, M.D.

A.M.A. REVISES THE "ESSENTIALS OF AN APPROVED INTERNSHIP"

An Advisory Committee on Internship, appointed by the Council on Medical Education and Hospitals in the fall of 1951, conducted a study in the past year reviewing the internship in its broadest aspects. As a result of its study the Advisory Committee recommended revisions in the "Essentials of An Approved Internship" which were ratified by the A.M.A.'s House of Delegates in December.

Among the changes in the requirements for hospitals offering intern programs were the following: Approval by the Joint Commission on Accreditation of Hospitals; bed capacity increased to 150, excluding bassinets; annual admissions increased to 5,000, exclusive of the newborn, and the autopsy rate increased to 25 per cent.

Under these revisions the Council will approve rotating and mixed internships and straight internships in these specialties—internal medicine, pediatrics and surgery. Straight internships in pathology and obstetrics-gynecology will no longer be approved.

The revised "Essentials" became effective January 1 for new approvals. The autopsy rate of 25 per cent became effective for all hospitals January 1.

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Tuberculosis Abstracts

Issued Monthly by the National Tuberculosis Association

Vol. XXVI FEBRUARY, 1953 No. 2

CLINICAL EVALUATION OF A REHABILITATION PROGRAM FOR THE TUBERCULOUS

By David Leibovici, M.D., Medical Annals of the District of Columbia, May, 1952.

In 1943 the former tuberculosis sanatorium of the District of Columbia was reopened as a rehabilitation center for tuberculous patients. The center was intended to serve two important purposes: It would alleviate a serious bed shortage for the treatment of tuberculosis; and it would bridge the gap between the sanatorium treatment of the patient and his return to normal activity in the community. The purpose of the study reported here was to determine whether or not the rehabilitation program reduced the number of relapses and readmissions.

It might be well first to briefly summarize the hospital program. The hospital is a 125-bed institution under the administrative supervision of the Municipal Hospital. Patients are admitted from both the Health Department hospitals. Requirements for admission are residence in the District of Columbia, negative sputa and gastric washings, stable x-ray findings, and the ability to handle such self-care activities as dressing and attending meals in the dining room. Treatment, such as pneumothorax, pneumoperitoneum and thoracenteses, is continued. X-ray films of the chest are taken at two-month intervals. Consultation service is available through the clinic at the Municipal Hospital.

Occupational therapy is prescribed for all patients and all patients are also seen by the vocational counselor. Regular staff conferences are held. These are attended by the physician, nurses, occupational therapists, vocational counselor, and medical social worker. At conference the plan for the patient's rehabilitation is reviewed, any modification of program is decided, and finally, discharge is considered when all members agree that existing problems have been met as fully as possible.

The ideal criteria for discharge are: (1) Disease inactive, with laboratory examinations negative and x-ray appearance stable; (2) Complications, if present, either not serious or successfully treated; (3) Work capacity demonstrated and adequate for future plans; (4) If gainful employment is necessary and patient is not yet working, prospects for employment fair; and (5) Social and home conditions are satisfactory.

The follow-up study was done to evaluate this program of rehabilitation. It was based on the replies to yearly follow-up letters sent to former patients, the checking of admissions to other hospitals in the District, and interviews with former patients. All information received was checked against the files of the Tuberculosis Bureau's Central Registry.

The study was limited to patients discharged from the opening of the hospital in 1943 through December 31, 1949. The status was determined as of June 30, 1951, so that the post-discharge period ranged from a minimum of eighteen months to a maximum of over eight years. The follow-up was limited to those patients who were at the center more than one month and who were discharged with inactive disease. This group of 716 patients was divided into sub-groups, according to type of discharge. In the follow-up investigation, information was obtained for 641 patients. The clinical status of seventy-five patients remained unknown and this group was excluded from the statistical analysis.

The analysis, then, is based upon a group of 641

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discharged patients whose clinical status was known. There were 505 patients discharged with advice, of whom it was found that: 366, or 72.5 per cent, were alive and well; eighty, or 15.8 per cent, were rehospitalized after their discharge from the center; thirty-seven, or 7.3 per cent, were dead of tuberculosis; twenty-two, or 4.4 per cent were dead of other causes.

The two groups of "walk-outs" and "disciplinary discharges" have a similar rate of relapse and death from tuberculosis, and for the purpose of study were combined into a single group of 136 discharges against advice, of whom: sixty, or 44.0 per cent were alive and well; forty-eight, or 35.0 per cent were rehospitalized; twenty, or 15.0 per cent were dead of tuberculosis; eight, or 6.0 per cent were dead of other causes.

Thus, of patients discharged with medical advice, 72.5 per cent weer alive and well and had never been rehospitalized; whereas, of patients discharged against medical advice, only 44 per cent were alive and well. Before concluding that the completion of rehabilitation was probably significant in the small number of relapses found in the first group, it was necessary to determine that the two groups were comparable in other respects.

Detailed comparison of the two groups showed that they were comparable with regard to age, marital status, diagnosis, treatment, onset of illness, length of hospitalization prior to transfer here, number of previous admissions to the sanatorium, and education. These factors then could not explain the difference between the two groups. Furthermore, race and sex length of stay at this hospital, clinical condition at discharge, and alcoholic history, did not explain the differences between them.

A correct evaluation of a rehabilitation program necessitates the comparison of two groups of patients, equal in all respects except that one group shall have had rehabilitation and the other shall have been discharged without rehabilitation. Moreover, both groups should have been discharged during the same period of time. To meet such criteria in the present instance was impossible. It was necessary to compare a group discharged medically with a group discharged against advice. The patients admitted to the center are selected in one respect. They are the more cooperative patients as the non-cooperative patients either walk out or are discharged before they are ready for transfer to this hospital. The patients discharged against advice from the center had accepted the purely medical and surgical treatment of the disease but refused the rehabilitation necessary to maintain the benefits of treatment.

The paients discharged with advice had completed the activity program at the hospital; had demonstrated adequate physical capacity for their future plans; and, had vocational guiadnce and selective placement in employment. The patients discharged against advice had left the hospital before their physical capacity was fully developed, and before vocational plans were completed.

The aim of rehabilitation of the tuberculous is to bridge the gap between the sanatorium and the community and to effect the gradual transfer of the patient from the sanatorium to the home. When we succeed in "controlling" a patient's disease we must understand that this is occurring in a "controlled" environment. After the patient leaves the hospital, economic and social factors appear which were not evident during active treatment. In the present study it was found that patients who completed rehabilitation, and who were discharged when judged ready for return, did much better than those who did not complete their rehabilitation. Rehabilitation is a definite part of the treatment of tuberculosis and is of benefit to the community in reducing costly readmissions to the hospital, loss of earning power, and expenditure of public funds.

Doctors Should Know These Facts!

Doctors, like other professional men, are often misled on their insurance. Many doctors, insured under a group plan, think that they have an exceptional deal because they believe the rates to be low and the coverage adequate. The fact that the "association" has approved it, makes it impressive to them. Thus, doctors are lulled into a false sense of security . . . they neglect to find out about the ever present CANCELLATION PROVISIONS. These provisions mean that this type of insurance may be cancelled for any of the following reasons:

1 If the **required premium** for the member has not been paid by due date, your coverage terminates.

2 When a member ceases to be a member of the insured group.

3 When the member retires or ceases to be actively engaged in his profession.

4 If the Insurance Company decides to cancel the plan.

These limitations, placed in the insurance contract, are "escape clauses" which allow the Company relief from responsibility.

Various doctors and dentists groups have been cancelled out when too many of the doctors became claimants. Even if the company does not cancel (which it may at its option) it may raise the premium to an unreasonable amount as its alternative. These cancellation provisions may be exercised by the company at a time when you may vitally need this coverage, and when you might be unable to get it elsewhere.

WHAT TO DO ABOUT IT . . .

Review your present policy. Go over it with your agent. If it contains any of the above provisions, you should not rely upon it!

The only kind of disability income insurance that you can afford to carry is the NON-CANCELLABLE, GUARANTEED RENEWABLE, LEVEL PREMIUM policy. This means (1) that the insurance **cannot, under any circumstances, be cancelled** by the company as long as the premiums are paid; (2) it means that it is guaranteed to be renewable to you, regardless of your age or occupational status, up to age 65; and (3) it means that you pay one premium rate throughout the policy's existence . . . your rate is fixed and cannot be changed as long as the policy is in force.

Don't rely on cancellable insurance! For complete facts on NON-CANCELLABLE insurance write to Thomas B. Anderson, G.A., and receive FREE, at no obligation to you, a factual booklet outlining the specific provisions of health and accident insurance. It is extremely important that you know these facts. Drop a card in the mail now while you're thinking about it.

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1 Schoenheimer, R., Ratner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

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1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.

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